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A REVIEW OF 70 CASES OF HIATAL HERNIA, WITH PARTICULAR REFERENCE TO SYMPTOMATOLOGY.[1]

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AND

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ALTHOUGH much has been written on the subject of hiatal hernia both in Britain and in America, there has been little reference to this subject in Australian literature (Robb, 1953; Morrow, 1952). This, together with the fact that consideration of this condition appears to have escaped the minds of many clinicians, stimulates us to review the subject, with particular reference to the clinical analysis of 70 consecutive cases encountered within the short space of two years.

Anatomy and Pathological Physiology.

Normally, the œsophagus passes through the œsophageal hiatus in the diaphragm, takes a sharp turn backwards and enters the stomach at the cardio-œsophageal junction obliquely (Figures I and II). Although there is no true sphincter mechanism at the cardio-œsophageal junction, food is prevented from being regurgitated into the œsophagus by a combination of three factors: (i) the pinchcock action of the diaphragm at the hiatus caused by contraction of the fibres of the right crus surrounding the œsophagus; (ii) the angulation of the œsophagus caused by the contraction of the fibres of the crus; (iii) the acute angle at which the œsophagus enters the stomach. The fibres of the diaphragm forming the hiatus arise from the right crus, pass upward to the left and encircle the œsophagus in a way likened by Allison to the pubo-rectalis encircling the ano-rectal junction.

With the development of the classical sliding type of hiatal hernia, there is a splitting backwards of the fibres of the right crus going to form the hiatus, which allows the passage of the stomach into the chest (Figures III and IV). The phrenico-œsophagus ligament, which is a condensation of fascia on the undersurface of the diaphragm, and which passes up through the hiatus to blend with the fascia over the œsophagus, becomes stretched and also ascends into the chest, taking with it a peritoneal covering to form the hernial sac. This then allows the angle of entry of the œsophagus into the stomach to be changed from one of obliquity to almost a direct passage (Figures V and VI).

The loculus of stomach situated in the mediastinum can become distended with air or food, so that pain is produced

[1] The substance of a paper read at a meeting of The Royal Australasian College of Physicians on October 14, 1954, at Sydney.

with a distribution outlined later. The interference with the sphincter mechanism leads to free reflux of gastric juices from the stomach to the œsophagus, with its attendant symptoms of vomiting and heartburn. With this free reflux the stage is set for the development of œsophagitis, which causes burning substernal pain especially on swallowing, and, if it is protracted, dysphagia from actual stricture

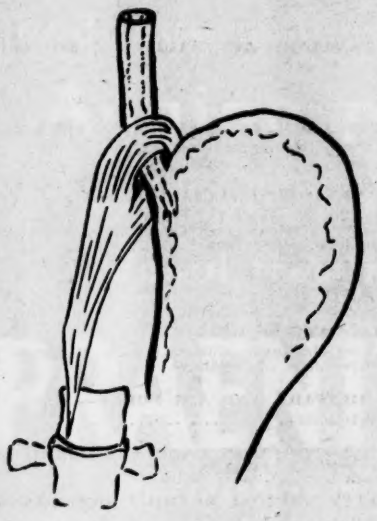


FIGURE I.

formation. With the development of the stenosis there occurs also a cicatricial shortening of the œsophagus, which may be so great as to preclude operative reduction of the hernia. The condition described as "congenital short œsophagus" is in most cases the end result of this process. Why it is that of all patients getting this reflux only a few get œsophagitis is not clearly understood. Certainly the incidence of œsophagitis is not directly related to acidity of the gastric juice. A most enlightening paper by Aylwin from Allison's clinic at Leeds suggests that the œsophagitis is related to the peptic activity of the juice secreted by the mucosa in the herniated portion of the stomach (Aylwin, 1953). The juice bathes the lower part of the œsophagus at night when the patient is recumbent, and at the time when all the normal protective elements—for example, food, saliva, œsophageal mucus—are at a minimum.

The second type of hiatal hernia, the rolling or para-œsophageal type, develops invariably in front and to the side of the œsophagus, possibly into a preformed sac. Here the œsophagus remains below the diaphragm, and the entrance to the stomach remains oblique and portion of the stomach rolls into the hernia (Figure VII). No reflux takes place, and so there is no attendant œsophagitis. There will be symptoms resulting from distension of the loculus in the mediastinum, and there may be dysphagia or even vomiting due to the distended loculus pressing on the œsophagus and increasing the angle of entry into the stomach. The extreme cases of this type occur when the whole stomach passes up into the hernial sac, producing an "upside-down" stomach, with perhaps complete obstruction or even strangulation (*vide* reports of cases).

Material.

The material reviewed in this paper consists of 70 consecutive patients, 19 males and 51 females, whose ages ranged from twenty-six to eighty-two years. Operation has been considered necessary in 23 of these cases, and may become necessary in others at present being managed conservatively.

We have attempted to classify the cases into groups according to the syndromes with which they presented to us. These are as follows, some cases falling into more than one category: (i) the condition simulating pain of cardiac origin, sufficient to have caused a diagnosis of cardiac disease to be suspected or made by a doctor, 15 cases; (ii) a history suggestive of cholecystitis or post-cholecystectomy syndrome, nine cases; (iii) a classical history of hiatal hernia with regurgitation and œsophagitis, 28 cases; (iv) œsophageal obstruction, 12 cases; (v) anæmia, with or without hæmatemesis and/or melæna, 10 cases.

Symptomatology.

The reported incidence of hiatal hernia in patients with abdominal symptoms varies from 2% to 10% in series reported by different authorities.

William Cernock, investigating the incidence of asymptomatic hiatal hernia by barium meal X-ray examination, found that of 200 patients aged over fifty years, with no symptoms referable to the alimentary tract, 1·5% had hiatal hernia, whereas of 3448 patients aged over fifty years, with alimentary symptoms, the incidence was 8·9%. When one adds the patients in whom the condition remains unsuspected, including the "pseudo-cardiacs", the wrongly diagnosed "nervous dyspeptics" and "air-swallowers", and those with so-called "refractory" anæmia, one realizes what a relatively common condition this is.

The commonest symptom of which the patient complains is pain. The pain is most commonly epigastric or substernal or both, but it may occur in the left or right upper quadrant of the abdomen or in the chest. In the chest it may occur on the right or left side, particularly in the left inframammary region, with or without a substernal component. The pain is often preceded by mild epigastric discomfort frequently accompanied by eructation of wind, which may relieve the pain.

When œsophagitis is present the pain becomes burning in nature, has a substernal component, and may radiate through to the back and rise into the neck and even into the jaw, ear or palate. It may also radiate into shoulders

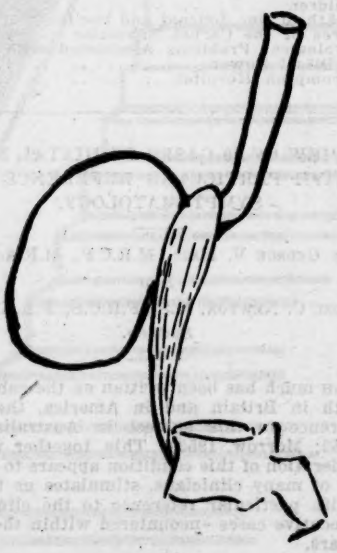
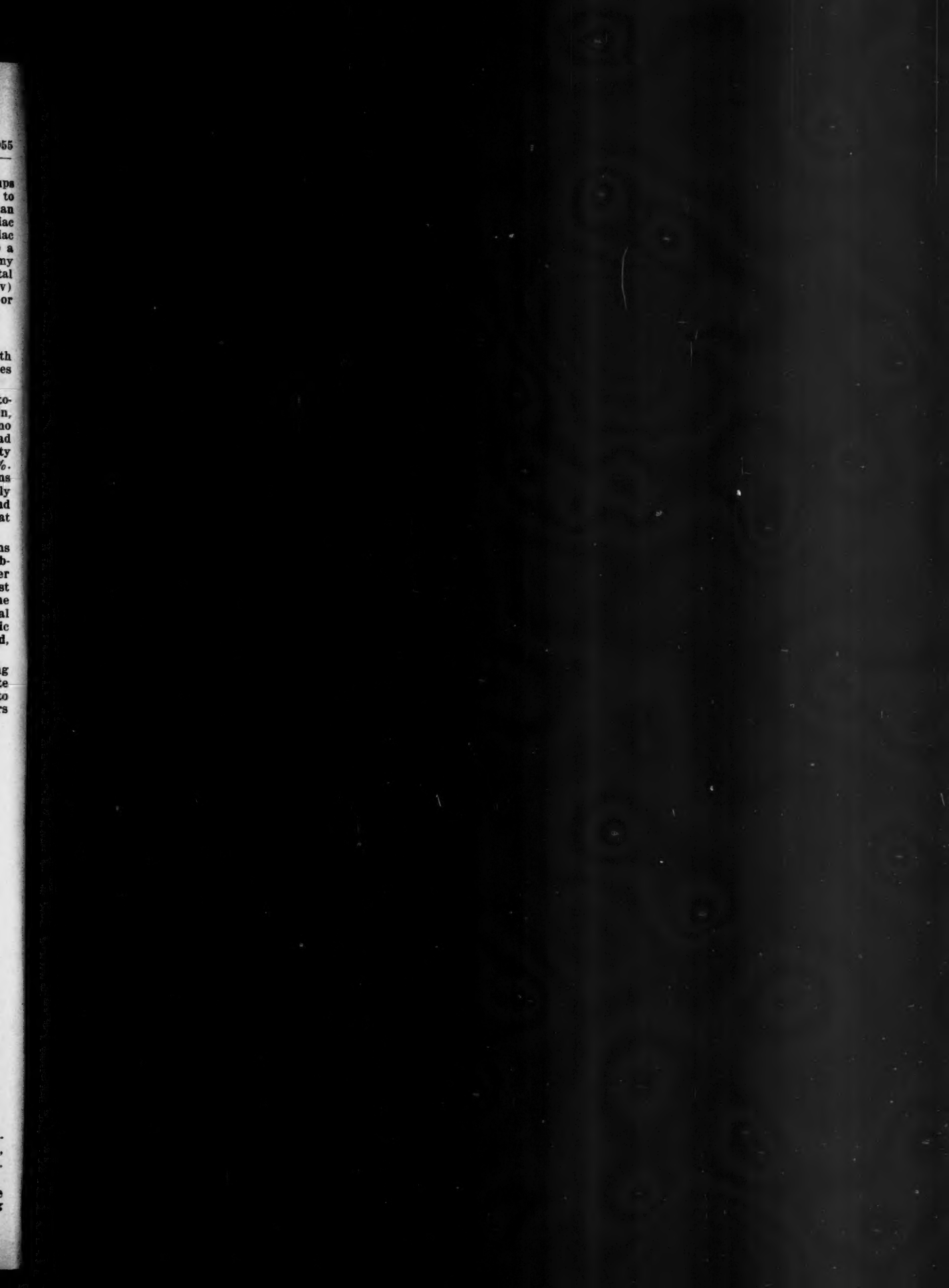


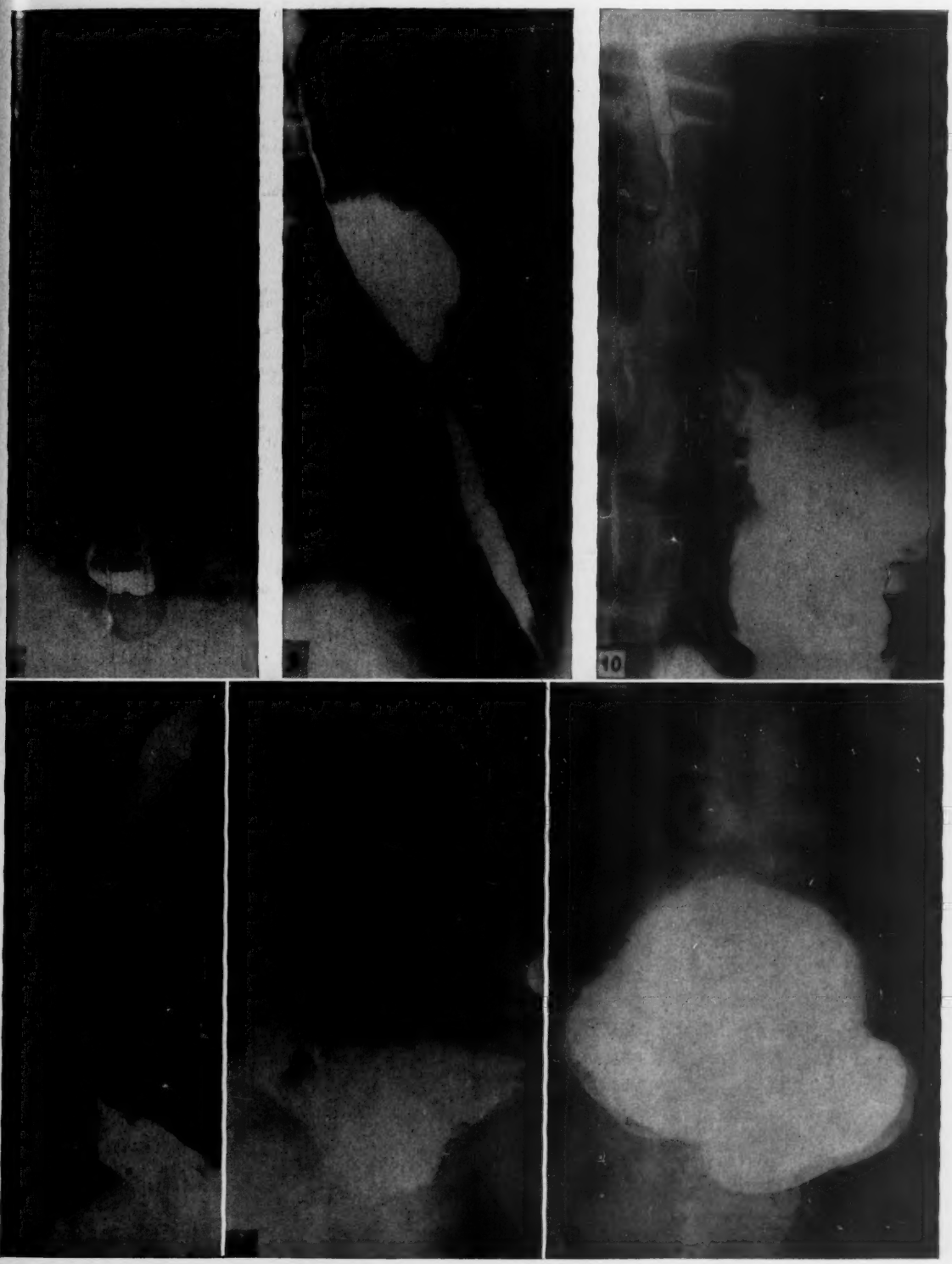
FIGURE II.

and arms, particularly the left. These patients also complain of an awareness of food passing down their gullets, and of actual pain caused by the passage of food. Ultimately dysphagia may occur.

The pain is induced by exertion, especially while the subject is leaning forward. It may wake the patient during



ILLUSTRATIONS TO THE ARTICLE BY GEORGE V. HALL, M.R.C.P., M.R.A.C.P., AND NOEL C. NEWTON, M.S., F.R.C.S., F.R.A.C.S.



ILLUSTRATIONS TO THE ARTICLE BY A. J. BARNETT.

FIGURE V.

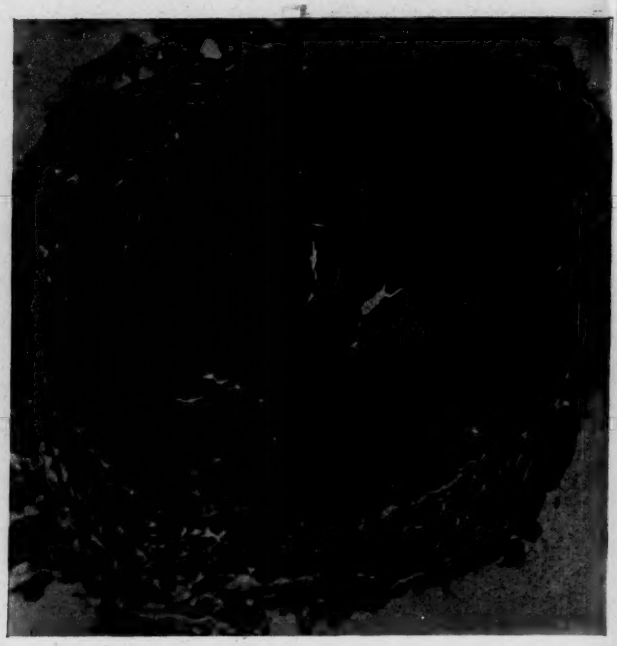


FIGURE XI.

ILLUSTRATIONS TO THE ARTICLE BY W. MAXWELL.

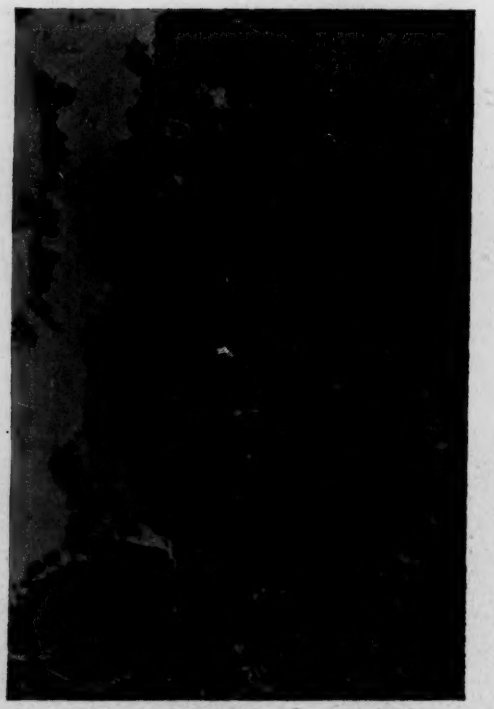


FIGURE II.

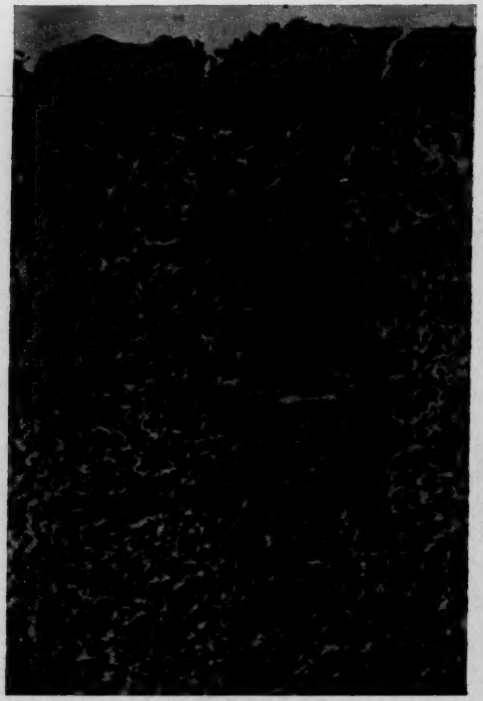


FIGURE III.

the night and be relieved by sitting up or getting out of bed. It is often relieved by alkalis or simply by drinking water.

Many patients complain that the pain is accompanied by a burning feeling or a dry feeling in the throat, and others complain that hot fluid or "acid" rises into the mouth when they are bending forwards or lying down in bed.

Another type of pain of which a number of our patients complained was acute precordial pain or distress most frequently concentrated in the left lower thoracic region, but occasionally with a substernal component. With this there was at times pain in the neck and left arm, or a sense of fullness or distension in the left side of the chest, at times amounting to the feeling that the chest was actually swollen and larger than the other side. This type of pain often followed eating, but the postural emphasis was not particularly marked. It is this pain which was frequently confused with pain of cardiac origin.

FIGURE III.

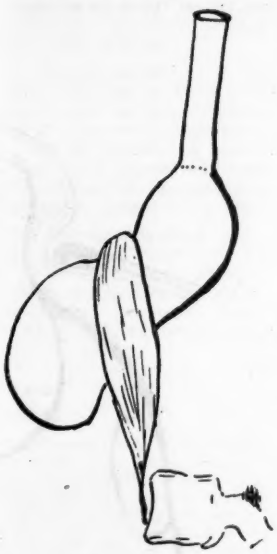


FIGURE IV.

There is a regrettable tendency to accept pain in the chest as cardiac pain if no other cause is obvious, and several of our patients had been made cardiac invalids without real justification. Severe chest pain has been regarded as due to coronary pain without electrocardiographic evidence or in the presence of a normal electrocardiogram. If such serious errors are to be avoided, it must be realized that the interpretation of chest pain is often a difficult problem calling for careful assessment.

Firstly, the history must be accurate in regard to the site and radiation of the pain, the nature of the pain, and its relation to exertion, posture and eating. Here it is vital that the following points about cardiac pain be remembered: (i) When an accurate history can be obtained, it is found that cardiac pain is hardly ever sharp, stabbing or "knife-like". (ii) It is hardly ever confined to, or concentrated in, the inframammary region on the left. (iii) If the heart is adequately investigated by full clinical, radiological and electrocardiographic methods, there are a very small number of cases of true cardiac pain in which entirely negative results are obtained.

It is important to stress that an adequate knowledge is required in interpreting electrocardiographic findings. Too often we see errors in diagnosis because the electrocardiographic record taken is incomplete, or because minor but significant changes have been overlooked. On the other hand, significance is often read into findings where it does not exist. Again, it is not fully recognized that when the electrocardiogram taken with the subject at rest is normal, another should be taken after exertion.

In addition to pain, patients with hiatal hernia may complain of flatulence, distension of the upper part of the abdomen, dysphagia, regurgitation of fluid into the mouth and heartburn. Some complain of a foul taste in the mornings, or recurrent ulceration in the mouth. Regurgitation of food without warning, particularly at the commencement of a meal, was complained of by others. Patients with hiatal hernia may present for the first time with hæmatemesis or melæna or both. The bleeding may be severe and profuse, and in one of our cases was of such severity that the patient came to operation in the acute stage.

Symptoms of anæmia may be the main presenting symptoms, although when the history is fully elicited other symptoms are almost invariably present. The anæmia may be normochromic and normocytic, but when due to chronic blood loss it may be hypochromic and microcytic in type. There is little doubt that even in the absence of demonstrable blood loss, progressive and refractory anæmia does occur which is cured by cure of the hernia.

Allison (personal communication) agrees that œsophagoscopic findings may be normal when anæmia is present and a source of blood loss may not be demonstrable. He writes:

> Anæmia of a secondary type, associated with large hiatal hernia, is not uncommon in the absence of gross ulceration or bleeding. My experience coincides with yours that if blood is restored to normal and the hernia reduced, anæmia does not return. I am not sure of the explanation, but it must be something to do with either stomach hormones or impaired iron absorption, but I am satisfied it is not due to bleeding.

Thus it seems that in refractory anæmia of this type hiatus hernia should be considered as a cause. A number of patients in our series have been treated over long periods with iron and liver injections, and apparently little thought has been given to the type of anæmia and its probable cause.

Diagnosis.

In our opinion it is desirable that the main clinical syndromes caused by hiatal hernia should be widely known, for it is only by awareness of the possibility that the diagnosis can be suspected. Direct questioning is often necessary to elicit many of the symptoms, especially those related to reflux. The patients do not usually lose weight, are often stout and look well, and are therefore often dismissed as neurotics or functional dyspeptics. As Allison points out, such a relatively common condition "deserves more notice and better treatment".

Radiology.

If the diagnosis is suspected clinically, the radiologist should be specially asked to look for evidence of hiatal hernia or œsophageal reflux.

The lesion cannot be demonstrated radiographically unless the patient is postured in one or all of the positions found usually to demonstrate the lesion—for example, with the patient supine, especially when the latter is tilted to the right and allowed to lie quietly for several minutes. Pressure in the epigastrium by the radiologist's hand, efforts at straining, and drawing up the knees, should be tried. Allison suggests filling the stomach with barium and then examining the patient fluoroscopically, the latter bending forward as though to touch the toes. Even when all these efforts fail to show the hernia, there will usually be free reflux of the barium into the œsophagus, which is a most important observation and one often not recorded in the X-ray report.

Failure to demonstrate the hernia radiographically does not in any way rule out the diagnosis of hiatal hernia. Several of our patients, in whom radiological examination failed to demonstrate the hernia, were shown at operation to have a hiatal hernia and were cured of their symptoms by its repair.

It is worth recording that more than half our series of patients had had one or more previous barium meal X-ray examinations carried out, with failure to demonstrate the hernia.

Œsophagoscopy.

An œsophagoscopic examination should be carried out in all cases, for it serves several useful purposes, as follows. (i) It can be diagnostic in the absence of radiological demonstration of the hernia. This has proved so in four of our cases. (ii) It shows the presence and degree of œsophagitis. (iii) It shows any stricture and allows dilatation and biopsy of the stricture.

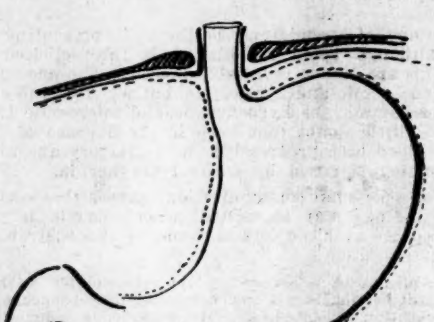


FIGURE V.

In our experience the findings at œsophagoscopy are quite classical. The œsophagoscope when passed to the lower end enters the stomach and gives a clear view of the gastric mucosa without meeting the normal diaphragmatic pinchcock, and when the œsophagoscope is withdrawn the gastric mucosa follows the withdrawal of the instrument

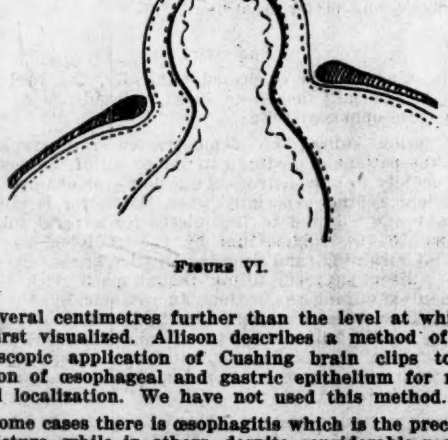


FIGURE VI.

for several centimetres further than the level at which it was first visualized. Allison describes a method of œsophagoscopic application of Cushing brain clips to the junction of œsophageal and gastric epithelium for radiological localization. We have not used this method.

In some cases there is œsophagitis which is the precursor of stricture, while in others, despite considerable regurgitation, normal mucosa is present. This knowledge is important in deciding the best method of management, for in the presence of œsophagitis operation is strongly advised, while in its absence operation can be safely deferred.

The presence of stricture is well seen on œsophagoscopic examination, and an opportunity is afforded to take a biopsy specimen from the site of the stricture and dilatation can be performed. It is often of value after dilatation to take for biopsy some of the tissue below the stricture. This may confirm the presence of gastric mucosa immediately below the stricture.

Biopsy in these cases is needed to exclude a malignant basis for the stricture.

Prognosis.

An hiatal hernia in an adult does not usually affect the expectation of life, but the morbidity in terms of discomfort and distressing complications is high. Each case, therefore, should be fully assessed on the symptomatology and on the radiological and œsophagoscopic findings, and a prognosis can be given for each case.

Broadly speaking, the prognosis is reasonably good with adequate medical treatment when œsophagitis is absent and when there is no obstruction.

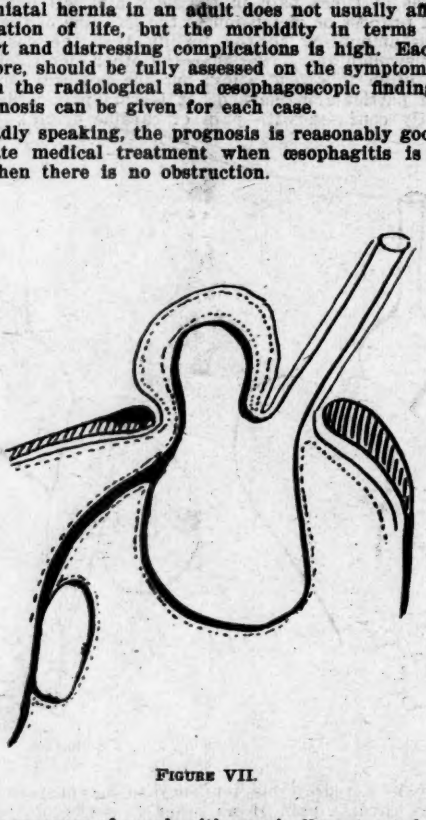


FIGURE VII.

In the presence of œsophagitis surgically untreated, hiatal hernia is most likely to proceed to stricture formation, which is difficult to treat, and when well established requires an operation of considerable magnitude for cure.

Treatment.

Medical Treatment.

In a condition such as this, which is essentially mechanical in origin, one would expect medical treatment to offer only palliative or psychological relief. However, the milder cases can be managed successfully over long periods by non-surgical means.

The most important point in the medical treatment is to insist that the patient sleep with the head of the bed raised at least nine inches above the level of the foot, and propped up with pillows, for it is during the night that the gastric secretions have most chance to damage the œsophagus.

The buffering of the stomach contents with alkalis and small frequent meals is probably worthwhile, and at least affords symptomatic relief.

The patient should avoid recumbency after meals, and while moderate exercise is permissible, heavy lifting and straining are best avoided.

Heavy patients should reduce their weight, and women should be advised not to wear tight corsets, which tend to induce herniation of the stomach through the hiatus.

Surgical Treatment.

Indications for surgical correction of the hernia may be summarized as follows: (i) the absence of œsophagitis in patients whose symptoms are sufficiently severe despite medical treatment, and whose general condition does not preclude operation; (ii) the presence of œsophagitis in all cases, unless the patient's age and general condition preclude operation; (iii) the presence of anæmia due to hiatal hernia, in all cases; (iv) the presence of hiatal hernia causing hæmatemesis and/or melæna, in all cases; (v) the presence of stricture formation.

In this series a transthoracic approach has been used exclusively for repair of the hernia, the operation being essentially as described by Allison (1951).

In cases of œsophageal stricture the problem is much more difficult. The "bad risk" patients must be treated by medical means and repeated dilatation. We have several patients of this type being satisfactorily treated.

Those whose general condition permits should be given the benefit of something better than this, for as time goes on they will become progressively worse. If the stricture can be satisfactorily dilated, and if there is no excessive shortening of the œsophagus, it may be possible to repair the hernia and continue dilatation. The repair will end the conditions producing and perpetuating the œsophagitis and will allow dilatation with reasonable chance of success.

When the stricture is severe and the œsophagus grossly shortened, the above-mentioned measures will not be practicable, and these patients will require formidable operative procedure planned to allow excision of the stricture and œsophago-jejunal anastomosis. We have three patients for whom this would be necessary, but whose age and general condition preclude it.

Reports of Cases.

"Pseudo-Cardiac."

CASE I.—A male patient, aged fifty-one years, had had an attack of severe burning substernal pain three months previously. The pain was also present in the left side of the chest. He was at rest in bed at the time. He was admitted to hospital and treated with bed rest for a coronary occlusion. No electrocardiographic examination was made. He had a good deal of pain persisting in the left side of the chest whilst he was in hospital, and it had persisted to some extent since then. This pain had troubled him intermittently for the past twelve months and had been severe and disabling at times. It used to begin below the left nipple and at times radiate upwards. It was often associated with flatulent dyspepsia. He had suffered from this type of indigestion for as long as he could remember. He had frequently noticed that frothy fluid ran up into the mouth and throat, particularly at night. He had recently had some shortness of breath on effort, but no symptoms referable to other systems.

Full clinical examination of the patient revealed no abnormality in the cardio-vascular or other systems. An electrocardiogram was perfectly normal and showed no trace of a recent myocardial infarct. Fluoroscopic examination of the patient revealed a normal cardiac contour and mediastinum. X-ray examination with a barium meal revealed a sliding type of hiatal hernia, with œsophageal reflux. The hernia was repaired, with subsequent complete relief of symptoms.

This is a good example of a man made a cardiac invalid as the result of failure to assess his initial illness adequately.

"Hæmatemesis."

CASE II.—The patient was a man, aged sixty-eight years, who had been admitted to hospital after a hæmatemesis. He had a history of indigestion of ten years' duration. He suffered from pain in the epigastrium coming on soon after eating and in the early hours of the morning. This was relieved by alkali. He had no history of vomiting or dysphagia. An X-ray examination taken about four weeks prior to his admission to hospital had shown "deformity of duodenum due to ulcer". He had vomited blood in hospital on two occasions on the day of his admission. He was given a transfusion and treated medically, and had no further hæmorrhage. His blood pressure reached its normal level of 180 millimetres of mercury, systolic, and 130 millimetres, diastolic, and he remained well for nine days, when he again vomited about one pint of blood. He was given a further transfusion, but continued to lose blood, and surgical opinion was sought. In view of his age, hypertension, history of ulcer and repeated hæmorrhage, operation was advised.

At laparotomy there was a scar of a healed duodenal ulcer on the anterior duodenal wall, but no other evidence of ulcer could be found. There was a large hiatal hernia, with at least one-third of the stomach in the chest. This could be easily reduced. Gastrotomy was performed and no source of bleeding was found. Duodenotomy also failed to show the bleeding point. It was considered that œsophagitis was probably the cause of the bleeding, and the abdomen was closed and further medical treatment continued. He recovered uneventfully.

An œsophagoscopic examination revealed severe œsophagitis. An X-ray barium meal examination was asked for in order to get films of the hernia, but failed to show any herniation despite the fact that the radiologist knew the lesion to be present.

Operation for cure of the hernia was performed three weeks after laparotomy. The œsophagus in its lower third was still thickened and œdematous, but reduction of the hernia was easy. His progress was satisfactory, and he was symptom-free twelve months after operation.

This patient shows the interesting combination of duodenal ulcer with hiatus hernia, his symptoms being due at this time to the œsophagitis, which was severe enough to cause severe blood loss. Also, it illustrates the difficulty of always demonstrating the lesion radiographically.

"Unexplained Anæmia."

CASE III.—A female patient, aged sixty-two years, complained of indigestion of twelve months' duration. This consisted of pain in the epigastrium and in the left lower quadrant of the chest, extending into the back between the shoulders, especially when she ate a large meal or lay in bed at night. She said that on occasions she would regurgitate her meal soon after eating. She belched excessively. On occasions she had a sensation of food sticking at the lower end of the sternum. She had never had hæmatemesis or melæna. She had been treated for anæmia for twelve months with iron and liver injections.

A cholecystographic examination showed a normal gall-bladder. An X-ray film of the stomach taken twelve months earlier showed no lesion. Another X-ray barium meal examination with a special request to search for an hiatal hernia showed a considerable reflux of barium into the œsophagus and the presence of hiatus hernia (Figure VIII). An œsophagoscopic examination confirmed the laxity of the diaphragm pinchcock, but showed no œsophagitis. A blood count revealed microcytic hypochromic anæmia, with a hæmoglobin value of seven grammes *per centum*.

She was given a blood transfusion and underwent operation for cure of the hiatal hernia. Six months after operation she was well. X-ray examination revealed no reflux or hernia, and the hæmoglobin value had remained normal.

This case shows the presence of anæmia with no obvious source of blood loss; the anæmia was cured by cure of the hernia.

Stricture.

CASE IV.—A male patient, aged fifty-eight years, complained of dysphagia of one year's duration. His past history revealed that he had had indigestion with classical ulcer pain for eighteen years, relieved periodically by medical treatment. Three years prior to his admission to hospital he had a recurrence of pain, which was unrelieved by treatment, and to which was added burning substernal pain and pain in the left inframammary region. This was followed by a sensation of food sticking in his chest at the lower end of the sternum, which was relieved by vomiting of the food eaten. He was submitted to laparotomy for this and was told that "nothing was found". He was no better after operation. The dysphagia and burning substernal pain increased, and he was eventually able to swallow only liquids. At this time he had a severe hæmatemesis and was admitted to a hospital, and whilst in hospital he developed severe pain in the epigastrium and was operated on urgently for a "ruptured ulcer". He was told "nothing was found", and after an apparently stormy convalescence was discharged from hospital.

At this time he was examined by one of us, and an X-ray barium meal examination revealed a hiatus hernia and œsophageal stricture (Figures IX and X). An œsophagoscopic examination revealed gross œsophagitis of the lower third of the œsophagus, and a tight stricture, biopsy of which revealed inflammatory reaction and no evidence of carcinoma. The stricture was dilated twice a week for one month and then once a week for three months. Dilatation was always difficult, and within a few days of dilatation the patient was able to swallow only liquids. The patient's general condition was not good, and although resection with œsophago-jejunostomy was contemplated, it was thought unwise. He died in hospital from cerebral hæmorrhage after a dilatation.

This case illustrates the long history of dyspepsia which is characteristic of this condition. Later the symptoms indicating œsophagitis were added, and soon a stricture developed. The œsophagitis caused hæmatemesis. At no time was the true nature of the condition considered, and the patient was submitted to two unnecessary laparotomies. This stricture was tight and unresponsive, and the patient's general condition precluded operation.

CASE V.—A female patient, aged sixty-eight years, complained of dysphagia of five years' duration. She said that she had always been bilious, and for ten years had had attacks of pain in the epigastrium, in the right hypochondrium and between the shoulders after meals. She also had experienced pain, burning in character, at the lower end of the sternum, and food often seemed to stick. She found herself most comfortable sleeping on three pillows, and if she slipped down flat the pain often awakened her at night. She had for five years experienced a sensation of food sticking in the lower part of the œsophagus, and was forced to leave the table in the middle of a meal and vomit the food eaten. Liquids were her main diet. She had been investigated by cholecystographic and X-ray barium meal examinations on three occasions, and no abnormality had been found. X-ray barium meal examination revealed a hiatal hernia with some narrowing of the cardio-œsophageal junction.

An œsophagoscopic examination revealed severe œsophagitis of the lower part of the œsophagus, and a stricture which dilated fairly readily. The patient has been kept reasonably comfortable by medical means and intermittent dilatations.

This patient again had a long history of dyspepsia, the true cause of which was not suspected and not found on barium meal X-ray examination, despite three attempts. Œsophagitis has developed and a stricture has formed. Fortunately this has been kept under reasonable control by conservative means.

CASE VI.—A female patient, aged sixty years, was admitted to hospital complaining of weakness, lassitude and breathlessness, which had progressed for several months. Three weeks prior to her admission she had begun to vomit and could keep down only fluids at the time of her admission.

The patient was a thin, emaciated woman with a lemon-yellow tint to her skin and pronounced pallor of the mucous membranes. A blood count gave the following information: the hæmoglobin value was 7·8 grammes *per centum* and the erythrocytes numbered 2,600,000 per cubic millimetre; the leucocytes numbered 6000 per cubic millimetre. The blood picture was "typical of pernicious anæmia". Marrow puncture was performed and the pathologist reported "megaloblastic erythropoiesis".

A fractional test meal examination could not be performed because the patient could not swallow the tube.

Therapy was instituted for the pernicious anæmia, but the response was poor, and as the patient began to vomit all solid food an X-ray barium meal examination was performed (Figure XI), the report being as follows: "The barium passed down the œsophagus, which was constantly narrowed in its lower third, and this could be due to simple stricture or neoplasm. There was no evidence of ulcer crater or other abnormality to be seen in the stomach or duodenum" (Figure XI).

At this stage the patient was seen in consultation. A review of the films suggested hiatal hernia, stricture and œsophagitis. An œsophagoscopic examination revealed a tight stricture at 32 centimetres, with severe œsophagitis above. A biopsy specimen was taken and the stricture dilated. A further biopsy specimen was taken from below the site of the stricture. Examination of these two sections revealed (*a*) chronic non-specific inflammation in the œsophageal mucosa and (*b*) chronic gastritis.

In view of the patient's extremely poor general condition, a gastrostomy was established and forced feeding was commenced. Her blood picture improved and she gained weight, but was never well enough for major surgery to be seriously contemplated. The stricture has been dilated several times since.

It is interesting to note that a fractional test meal examination through the gastrostomy revealed a histamine-fast achlorhydria.

This patient shows what must be an extremely rare combination of hiatal hernia with severe œsophagitis and stricture in the presence of pernicious anæmia and histamine-fast achlorhydria.

Paraœsophageal Hernia.

CASE VII.—This patient was aged fifty-two years, and had a long history of dyspepsia, flatulence and a sensation of fullness in the lower part of the chest at times, especially after eating heavy meals. Vomiting of blood had occurred on one occasion three years previously. X-ray examination revealed paraœsophageal hernia. Operation was performed with relief of symptoms (see Figure XII).

CASE VIII.—A female patient, aged sixty-eight years, was examined because of a sudden attack of pain in the epigastrium and substernal region, radiating into the right hypochondrium, and associated with vomiting. This had persisted for several days. Examination of the patient revealed tenderness in the epigastrium, but no other significant abnormality. There was a long history of flatulent dyspepsia and occasional vomiting after a meal. A tentative diagnosis of cholecystitis was made and the patient was treated by bed rest and fluids given by mouth. The pain persisted and all fluids taken by mouth were regurgitated. She was given fluids intravenously and a barium meal X-ray examination was undertaken, as it was thought that there must be an obstruction at the lower part of the œsophagus.

X-ray examination revealed a large paraœsophageal hernia. There was delay in the entry of barium into the stomach, and when it did an "upside-down" stomach was revealed, with considerable delay in emptying through the pylorus. There was no complete obstruction. Conservative treatment was persisted with and the patient settled down after nearly three weeks in hospital. She has remained reasonably well since (see Figure XIII).

These are the only two cases of paraœsophageal hernia in our series. One shows the usual milder symptoms, while the other shows the complication that can occur when the whole of the stomach turns up into the sac.

Summary.

1. The anatomy and pathological physiology of the types of hiatal hernia are described.

2. The symptomatology is discussed and the common syndromes presented are described.

3. The prognosis and medical treatment are discussed.

4. Indications for surgical treatment are discussed.

5. The management of the established stricture is discussed.

6. Case histories of the various types of hernia are given, with comments.

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OCCLUSIVE ARTERIAL DISEASE OF THE HANDS.[1]

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The types of occlusive arterial disease in the lower limbs are few and well known, the chief conditions being *atherosclerosis obliterans, thromboangiitis obliterans* and traumatic thrombosis; they are usually readily diagnosed from the history and the clinical findings. In the upper limb the causes of arterial occlusion are more varied and less well known. It is the purpose of this paper to enumerate the types of arterial disease found in a series of patients with ischæmic disease of the hands, to describe briefly methods useful in diagnosing these conditions, and give thumbnail sketches of typical case histories. It is hoped that this will stimulate thought on occlusive arterial disease of the hand of obscure origin.

Terminology: "Raynaud's Disease" and "Raynaud's Phenomenon".

A classification of the types of occlusive arterial disease in the hands is made difficult because of confusion in terminology. Most cases of ischæmia of the hands, particularly if associated with colour changes, are diagnosed as "Raynaud's disease". Should there be a suspicion of some primary disease, the patient is said to be suffering from "Raynaud's phenomenon"; this term is also commonly applied to occasional attacks of white or "dead" fingers without any primary disease. It is well to consider what is meant by these commonly used labels. The term "Raynaud's disease" was used as a tribute to Maurice Raynaud, who collected a series of cases of ischæmia of the hands for his thesis in 1862 "On Local Asphyxia and Symmetrical Gangrene of the Extremities", and published further cases in 1874 in a second work entitled "New Researches on the Nature and Treatment of Local Asphyxia of the Extremities". He believed that ischæmia could result from functional neurogenic constriction of vessels without organic obstruction. Jonathan Hutchinson (1901) realized that the conditions being described as "Raynaud's disease" comprised a variety of pathological states, and suggested the term "Raynaud's phenomenon" for attacks of digital asphyxia from various causes. When instances secondary to known causes are eliminated, there remains a residue of cases in which the attacks are apparently due to some intrinsic vascular fault, and it is to these cases that the term "Raynaud's disease" is now applied by most authors. Allen and Brown (1932) laid down strict clinical criteria for this diagnosis. The minimum requirements were (i) intermittent attacks of discoloration of the extremities, (ii) absence of evidence of organic arterial occlusion, (iii) symmetrical or bilateral distribution, (iv) trophic changes when present limited to the skin and never consisting of gross gangrene. Secondary criteria were (i) predilection for females, and (ii) absence of pain. Lewis and Pickering (1933) discussed "Raynaud's disease" and described various other causes of digital ischæmia which had to be distinguished from it. Allen (1937) from radiographic study, and Lewis (1938) from pathological investigation, concluded that in Raynaud's disease the arteries were not structurally diseased. Lewis (1936) believed that the abnormality consisted in an intrinsic excessive responsiveness of the digital arteries to cold. It is paradoxical that the term "Raynaud's disease" as now used would exclude most of the cases described by Raynaud in his original thesis. It is a clinical rather than pathological diagnosis and is made on the basis of arbitrary criteria and the exclusion of other conditions. It probably includes more than one functional abnormality: some patients have attacks from local cold, others from general cold. The pathological basis is still unknown.

[1] This paper is based on a paper read at a meeting of the Australasian Cardiac Society in May, 1954.

Diagnostic Methods.

To save repetition during the clinical histories, the diagnostic methods used in the investigation of patients with ischæmia of the hands will be briefly outlined.

Clinical Observations.

Tests of Sufficiency of Larger Arteries.

The radial and ulnar arteries are palpated at both wrists. The hands are then held above the head and clenched and unclenched ten times. Deficiency of arterial inflow will be shown by undue pallor of the hand and slowness in return of the circulation. The sufficiency of the radial and ulnar arteries may be tested separately by compressing both these vessels at the wrist, asking the patient to clench and unclench his hand ten times and then releasing the artery being tested. In most normal persons the whole hand should flush from the tested side in about five seconds; in some, the hand is supplied predominantly by one or other artery.

Thoracic Outlet Tests.

Occlusive arterial disease of the hands may be secondary to pressure on the subclavian artery at the thoracic outlet. Compression by the *scalenus anterior* muscle may occur in certain instances of cervical rib or abnormal first rib and possibly also from over-activity of this muscle without these anomalies. It is tested by feeling the radial pulse while the patient abducts his arms to a right angle with the elbows flexed, rotates his head to the side being examined and takes a deep breath (Adson and Coffey, 1927). Obliteration of the pulse is considered to indicate pressure by the *scalenus anterior* muscle. Compression of the artery between the clavicle and first rib is tested by pulling on the slightly abducted arm, meanwhile feeling the radial pulse with the other hand. Obliteration of the pulse is considered to indicate such compression. Positive results from these tests may often be obtained from normal people. They are therefore of limited value.

Digital Vascular Tests.

The condition of the digital vessels is examined by the simple tests used by Lewis and Pickering (1933).

Cold Immersion Test.—The hands are immersed in water at 15° to 17° C. for ten minutes and inspected for any change in colour. Normally, the fingers remain pink at this temperature. Undue pallor or cyanosis may occur not only in Raynaud's disease, but in various conditions with structural disease of the digital vessels. The room temperature should be noted, and if this is high (23° C. or above) and there is no response from the test, it is advisable to repeat it on a cool day (room temperature 20° C. or below); Raynaud's phenomenon may be produced by local *plus* general cold, whereas it is not produced by local cold alone. The hands should be removed from the cold water and exposed to the air for a minute while still wet. Occasionally, although no colour change may be noted in the fingers during immersion, this may occur after their removal from the water.

Reactive Hyperæmia Test.—The hands are immersed in water at 35° C. for ten minutes; they are then removed from the water and raised above the head, and the arterial circulation is occluded by rapidly inflating cuffs applied to the arms. The hands are then returned to the water at 35° C. for a further five minutes. Each cuff in turn is then rapidly deflated, and the time for the flushing of the tips of the digits is noted. Normally this should occur within ten seconds; delay indicates occlusion of the arteries of the digit. The site of arterial block as indicated by this test correlates well with that shown by arteriography.

Hot Immersion Test.—The hands are immersed in water at 44° C. for ten minutes; they are then inspected for colour and capillary pulsation of the nail beds, and the digital arteries are palpated at the base of the digits. Normally the fingers become bright red, capillary pulsation is seen in all nail beds and arterial pulsation can be detected at either side of all digits. If the digital vessels are blocked by structural disease, the tips of the fingers

may be cyanosed, and capillary pulsation and digital arterial pulses absent. (This test is tedious, and the information gained adds little to that from the reactive hyperæmia test; it may usually be omitted.)

Instrumental Observations.

Calorimetry.

The severity of ischæmia can be measured by estimating the hand blood flow from the heat elimination as measured by calorimetry. The capacity for increase in this blood flow may be determined by a reflex hyperæmia test, in which the opposite limb is immersed in water at 44° C. for fifteen minutes.

TABLE I.
Occlusive Arterial Disease of Hands.

Condition.	Number of Cases.
Raynaud's disease	12
Mild Raynaud's phenomenon	2
Embolism from subclavian aneurysm	1
Arteriosclerosis	2
Scleroderma	5
Ischæmic symptoms associated with trauma to hand	1
Ischæmic symptoms associated with neurological disease	1
Digital artery occlusion, cause unknown	4
Ischæmic symptoms following sympathectomy	2
Total	30

Radiography.

The exact site of arterial block can be determined by arteriography. This is usually unnecessary for diagnosis, and merely confirms the deductions from the simple clinical tests. If there is suspicion of compression of the subclavian artery in the thoracic outlet region, plain X-ray pictures should be taken of this area.

Therapeutic Test.

Should sympathectomy be considered, a therapeutic test of the probable effectiveness of this operation may be made by injecting procaine hydrochloride into the ulnar and median nerves at the elbow or into the upper dorsal sympathetic ganglia. The second method is preferable, as it avoids the temporary muscular paralysis following injection into peripheral nerves.

PRESENT SERIES.

The diagnosis of "Raynaud's disease" has been made if patients had intermittent attacks of pallor or cyanosis of the hands or fingers occurring on both sides, without any discoverable primary cause and commencing before the age of forty years. The cases included are similar to those described by most recent authors, and the clinical features conform to those depicted in modern text-books dealing with vascular disease (Allen, Barker and Hines, 1947). Although in general the criteria of Allen and Brown (1932) have been fulfilled, evidence of organic arterial occlusion of the fingers has not been held to exclude the diagnosis, and complaint of some pain has been permissible.

The other instances of digital ischæmia have been listed under headings that seemed appropriate with our limited understanding of their cause, and no attempt has been made to fit them into some theoretically satisfying classification.

Reports of Cases.

Representative case histories will be given to illustrate the type of condition listed under the various headings in Table I. No attempt is being made in this paper to present the findings in detail or to discuss the mechanism of the disturbance, which is, in most instances, still obscure. The present aim is simply to paint a general picture of occlusive arterial disease of the hands.

Raynaud's Disease.

Our criteria for adoption of this diagnosis have already been given. Two case histories will be presented briefly to illustrate the clinical features.

CASE I.—A woman, aged thirty-seven years, said that for the past six years she had had frequent attacks of numbness and whiteness of the fingers of both hands, particularly the right. The attacks occurred only during the winter; they were brought on by cold and were particularly frequent when she was carrying objects in the cold weather, although they were not prevented by wearing gloves. They were not precipitated by emotional upsets. During the attacks the fingers were pale and numb and there was some pain, which was not very severe. The pallor of the fingers lasted up to an hour, but the attack could be shortened by immersing the fingers in warm water and then rubbing them with a towel. The fingers then became a normal colour and there

FIGURE I.
Arteriogram of left hand, Case V.

was a full, warm, tingling feeling in them. The feet were affected similarly to the hands, but usually less severely, and the attacks in the feet were relieved by exercise. The patient was admitted to hospital because of an area of skin necrosis on a toe following a prolonged attack of ischæmia.

There was no evidence of structural occlusion of the arteries of the hands. Between attacks the fingers were warm and pink, although the skin of the fingers of the right hand was rather thicker than that of the left. There was no radiological evidence of any thoracic outlet abnormality.

In view of the other clinical features indicative of Raynaud's disease, the slight thickening of the skin of the right hand after attacks of ischæmia for six years was not held to prevent this diagnosis.

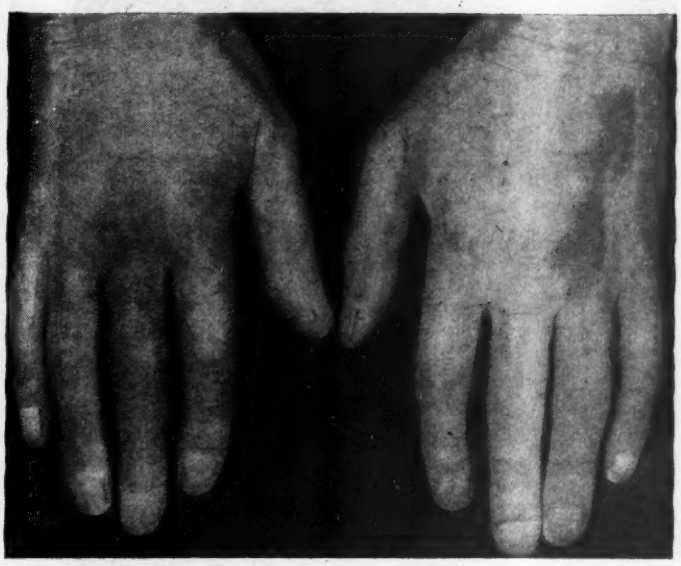

FIGURE II.
Hands of patient with severe scleroderma.

CASE II.—A woman, aged forty years, said that for over twenty years she had suffered from attacks of "deadness" and pallor of her hands and feet. These were brought on by cold and occurred particularly in the winter, but also during cold weather in the summer, and were not entirely prevented by wearing warm clothes and gloves. Although she was a very excitable person, emotional disturbance did not appear to be a factor. During the attacks the digits became extremely pale, "numb" and painful. Relief was obtained by the application of warmth; the digits would become blue, and then extremely red before returning to a normal pink colour. For the past two weeks the tip of the right ring finger had been tender and purple.

The radial pulses were normal. Mottled pallor and cyanosis were present in both hands. The right ring finger was persistently cyanosed, and the pulp felt hollow. Immersion of the hands in cold water (15° to 17° C.) resulted in cyanosis of all digits, most pronounced in the right fourth and in the left third and fourth digits. In response to an arterial occlusion reactive hyperæmia test, the flush reached the tips of the fingers at different times. There was considerable delay in flushing of the right fourth digit (the flush extended to the proximal interphalangeal joint in fifty-eight seconds, the tip was still cyanosed at two and a half minutes) and of the left third and fourth digits (sixty and fifty-two seconds).

FIGURE III.
Hands of patient with localized scleroderma. (The tips of the second, third and fourth digits of the left hand were lost as the result of an accident.)

The history and findings in this case indicated long-standing Raynaud's disease and more recent structural occlusion of digital arteries.

Mild Raynaud's Phenomenon.

Occasional attacks of pallor of one or more digits in response to cold, but giving no cause for complaint, are frequently mentioned by patients or by one's associates. The fact that only two patients with this disturbance are

listed in Table I (based on patients referred because of circulatory disturbance in their hands) indicates, not that it is rare, but that it is of insufficient importance to require medical advice.

FIGURE IV.
Hands of patient in Case VI, showing glossiness of skin of terminal parts of fingers.

One of the cases referred to in the table was of interest, in that the attacks were not produced by cold and affected the whole hand.

CASE III.—A girl, aged sixteen years, complained of attacks of whiteness of her right hand from the wrist down, occurring once a day and lasting about half an hour. After the pale stage the hand became red and tingled. The attacks were not produced by cold or by emotion, but occurred when she was simply walking about. She attributed the attacks to a sprain of the wrist sustained in a motor omnibus accident some two years previously. The only abnormality on clinical examination was a positive response to the *scalenus anticus* test on the right side. Heat elimination from the right hand was 43 calories per 100 millilitres per minute with a rise to 93 calories per 100 millilitres per minute from reflex hyperæmia (normal values).

The positive response to the *scalenus anticus* test may indicate some pressure from the muscle; but the response to the test is often positive in normal people. The symptoms in this case are not sufficiently severe to warrant surgical exploration. Meanwhile the diagnosis of mild Raynaud's phenomenon is applied.

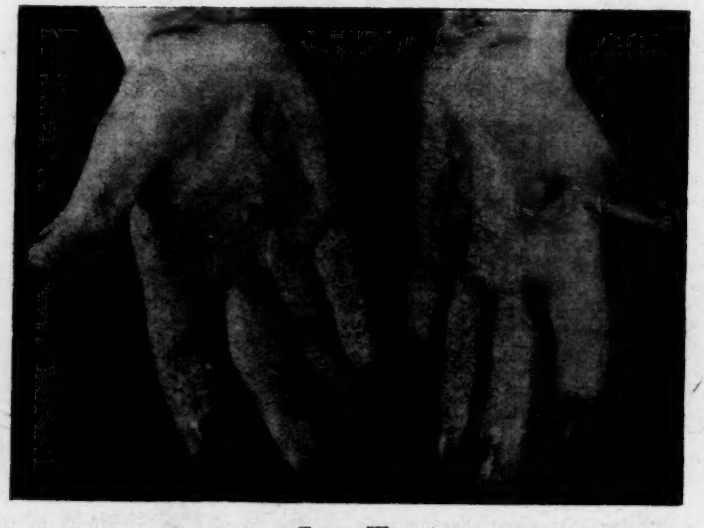

FIGURE VI.
Hands of patient in Case IX.

Embolism from Subclavian Aneurysm.

Occlusion of arteries of the hand by emboli from a thrombus in a subclavian aneurysm has been discussed by Lewis and Pickering (1933) and since then by many others.

CASE IV.[1]—A man, aged twenty-seven years, believed that he was suffering from Raynaud's disease (stating that this diagnosis had been suggested by the doctor attending his place of employment). On his being questioned, it was found that he was suffering from attacks of pallor of his left hand only. On examination of the patient a few days later, it was found that he had a pulsating swelling above his left clavicle and an absent left radial pulse. A diagnosis of an aneurysm of the left subclavian artery with embolic occlusion of arteries of the hand and forearm was made. The aneurysm was later exposed and an abnormal "first" rib resected.

Atherosclerosis.

Chronic coldness, cyanosis and ulceration of the fingers or attacks of ischæmia of the hands sometimes appear first in old age and are presumably due to atherosclerosic narrowing of the vessels, possibly with complicating thrombosis, as described by Lewis and Pickering (1933).

CASE V.—A woman, aged seventy years, complained of cold, painful hands over a period of two years. In the winter the fingers were blue, and soon after she rose in the morning were subject to attacks of pallor, which were relieved by a cup of hot tea. Painful ulceration had occurred in her finger-tips.

On examination of the patient, the hands were cold and blue and there were scars on the tips of several fingers. The radial pulses were normal. There was no clinical or radiological evidence of obstruction at the thoracic outlet. An arterial occlusion reactive hyperæmia test resulted in very slow flushing of the digits. Brachial arteriography revealed no abnormality of the main arteries of the forearm, but the left ulnar artery was occluded just above the styloid process and the digital arteries were very thin (Figure I).

Scleroderma.

The occurrence of Raynaud's phenomenon in scleroderma is well recognized (Hutchinson, 1901; Lewis and Pickering, 1933). Recent work (Beigelman *et alii*, 1953) indicates that this is very frequent. In the five cases in this report the patients were four men and one woman. In all instances symptoms commenced after the age of forty years. One man developed generalized scleroderma which was fatal. The condition of his skin when the disease was advanced is shown in Figure II. In the other three men the sclerodermatous changes have remained localized to the hands (Figure III). In the woman, the skin of the hands and the face is affected.

In the early stages, the vascular symptoms consist of attacks of Raynaud's phenomenon; later, there is chronic ischæmia of the hands with cold blue fingers and sometimes ulceration of the finger tips. Reactive hyperæmia tests have shown delayed flushing of the finger tips, indicating narrowing of digital arteries. The blood flow as estimated from heat elimination has been low, and there has been a poor response from a reflex hyperæmia test. In the men, the vascular disturbance has been confined to the digits and the findings have indicated obstruction of small arteries. In the woman, large vessels also have been obstructed.

Vascular symptoms may occur before it is possible to diagnose scleroderma from the appearance of the skin.

CASE VI.—A maintenance labourer, aged forty years, was examined in December, 1951, complaining that for the past four or five months he had suffered from attacks in which his fingers and toes became numb, stiff and very pale. These occurred particularly when he left his home in the morning to go to work. In the past two months the digits had become blue rather than white in the attacks, and recently had felt swollen, although the range of movement was normal.

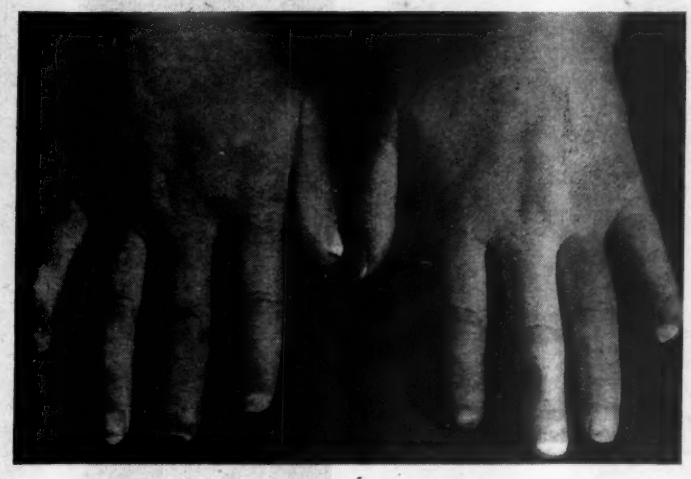

FIGURE VII.
Hands of patient in Case X.

No abnormality was found on general examination of the patient. There was no cyanosis or coldness of his hands or feet when he was examined in the out-patient clinic in warm weather, although when the skin of his fingers was blanched by pressure the return of colour was rather sluggish. The fingers of his right hand, particularly the index and middle fingers, were rather thicker than those of the left, although the changes were not considered indicative of scleroderma.

No cause for the symptoms was found, and there was no response to treatment. He was admitted to hospital in June, 1952, with a pulp infection of his right index finger, which responded to treatment with antibiotics. Calorimetry revealed a resting heat elimination from his left hand of 15 calories per 100 millilitres per minute, rising to 40 calories per 100 millilitres per minute from a reflex hyperæmia test. Injection of procaine hydrochloride into his left ulnar nerve resulted in a slow flushing of the ulnar side of his hand and corresponding fingers, with a skin temperature rise of approximately 6° C. Subsequently, an injection of procaine hydrochloride into the stellate and upper dorsal sympathetic ganglia produced a slow but satisfactory flushing of his hand.

The patient was not examined again for about eighteen months. The ischæmic symptoms in his hands had continued, and he had developed definite thickening of the skin of his fingers indicative of scleroderma (Figure IV). The heat elimination was practically the same as before.

[1] This case has been reported in detail (Fraser and Barnett, 1954).

Ischæmic Symptoms Associated with Trauma to the Hand.

In one case the history suggested that the ischæmic symptoms followed an injury to the hand.

CASE VII.—A man, aged thirty-four years, said that he had always had cold feet and hands. About six weeks prior to attendance he cut his left thumb in a circular saw. The wound failed to heal properly, and the interphalangeal joint felt dead. There was a continuous "gnawing pain" in the thumb, and because of this the wound had been opened six

FIGURE VIII.
Arteriogram in Case X.

times. His hands became blue a few days after the injury. The cyanosis was continuous except when the hands were warmed.

On examination of the patient, both hands were leaden-blue in colour, and there was an incised wound with indolent edges on the ball of the left thumb. The right radial pulse was moderately strong, but the left was weak. No abnormality was noted in the brachial pulses. The upper thoracic part of the sympathetic chain on each side was injected with 1% procaine hydrochloride solution, with the production of Horner's syndrome and conjunctival injection. The left hand flushed gradually, but the temperature of the fingers rose by only 1° C. The right hand also flushed slowly, but the temperature of the fingers rose by 9° C.

Unfortunately this patient failed to return for further investigation.

Ischæmic Symptoms Associated with Neurological Disease.

In the following case vascular features were the forerunner of a neurological disturbance, and both were probably due to the same cause.

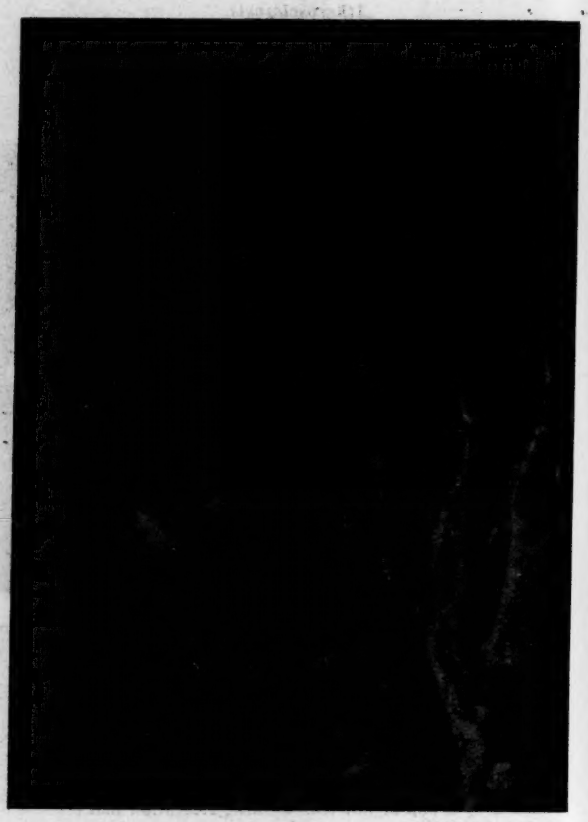

FIGURE IX.
Arteriogram in Case XI.

CASE VIII.—A woman, aged sixty-one years, had been troubled with "pins and needles" and pain in her hands at night and when she carried parcels. During the past six months her hands and feet had been cold, and she had been subject to attacks of pallor of the fingers. These attacks occurred particularly when she got out of bed, but also at other times. They were not precipitated by cold and would even happen when she was sitting by a fire. The hands would become white and painful for about fifteen minutes, then red and "burning" and later blue. Attacks of whiteness also occurred in her toes, but were less troublesome.

The radial and ulnar pulses and appearance of the hands were normal. Traction on the slightly abducted arms failed to obliterate the radial pulses. There was slight impairment of sensation to light touch over the fingers; otherwise examination revealed no abnormality. Radiographic examination of the cervical part of the spine revealed marked osteoarthritic changes, with pronounced narrowing of the disk spaces (Figure V). When examined a fortnight later the patient was complaining of pain in both thighs. X-ray examination of the lumbo-sacral part of the spine revealed osteoarthritic changes. Later, she developed weakness and wasting of her thigh muscles.

Neurological lesions associated with spinal osteoarthritis are well recognized. It is possible that the attacks of Raynaud's phenomenon were also due to this, being caused by an irritative lesion of the sympathetic nervous pathways.

Digital Artery Occlusion of Unknown Cause.

In the following instances severe ischæmic symptoms of the fingers were associated with clinical or radiological evidence of arterial occlusion. In none of the cases has a cause been firmly established. In the first case there were features suggestive of *thromboangiitis obliterans*, in the second there was some evidence of abnormality in the thoracic outlet region, in the other two the origin of the malady is completely obscure.

CASE IX.—A woman, aged forty-nine years, said that four weeks earlier she had developed a painful right index finger. This was incised and seemed to be improving, but later the tip became black and ulcerated. One week prior to examination, her left little and index fingers became numb, painful and white at the bases; the tips later became black. There was no past history of vascular disturbance. She had not taken any drugs likely to cause circulatory trouble, but smoked 30 cigarettes per day. Her blood pressure was 170 millimetres of mercury, systolic, and 100 millimetres, diastolic; a systolic murmur was heard at the cardiac apex and base, and the urine contained a trace of sugar. The radial pulses were normal and the hands warm except for the affected areas of the fingers, which were necrotic (Figure VI). Radiographic examination revealed no cervical rib. The necrotic tissue separated, and healing occurred.

Ten months later the patient was readmitted to hospital with a gangrenous right fourth toe and absence of ankle pulses in the right foot. No cryoglobulins or cold agglutinins were found in the serum. The clinical history indicated occlusion of several small arteries. Had the patient been a young man, *thromboangiitis obliterans* would have been diagnosed.

CASE X.—A woman, aged thirty years, said that for "many years" her fingers had become white and painful on exposure to cold. Over the past ten years she had suffered from "infections" in practically all her fingers; after these the ends of the fingers dried up and became black. After bilateral cervico-dorsal sympathectomy three years earlier the hands were drier and warmer; but she still had occasional attacks of whiteness of the fingers, and still had attacks of painful, "infected" fingers.

The hands were warm and pink. There was considerable deformity of all the fingers, with shortening and curvature of the nails (Figure VII) and purulent infections of the thumbs and index fingers. The right radial pulse was readily obliterated by traction on the arm, and the left radial pulse, although not affected by this manœuvre, became much weaker when the arm was abducted to a right angle. X-ray examination showed that there was no cervical rib. An arteriogram of the left arm showed obstructive lesions of radial, ulnar and digital vessels (Figure VIII). The right side of the neck was explored surgically. A firm band of fibrous tissue was found passing behind the subclavian artery and attached to the scalene tubercle; it could have been compressing the artery, which, however, appeared and felt normal. This band was divided, but there was no appreciable change in the condition of her hand.

CASE XI.—A woman, aged forty-two years, complained that over the past five years attacks of blueness of the hands occurred when she carried heavy parcels, when she was tired, or when she put her hands in cold water. For several months she had had painful ulceration of one of the fingers of her left hand. Her feet had been blue on occasions over the past eight months. Four weeks earlier a left cervico-dorsal sympathectomy had been performed. After this her left hand was warmer and of a better colour; her right hand remained unchanged.

About five months after the sympathectomy the condition of her left hand rapidly deteriorated; it became cold, and there were intermittent attacks of blueness of the fingers. Calorimetry showed a low heat elimination from both hands, and no increase from a reflex hyperæmia test. On immersion of the hands in cold water the fingers became cyanosed. An arterial occlusion reactive hyperæmia test showed delayed flushing of all the fingers. Arteriography revealed blocking of numerous small arteries (Figure IX).

The possibility of a disturbance at the thoracic outlet was considered, but as there was no X-ray evidence of abnormality in this region, and as there were deficient pulses in the lower limbs, exploratory operation was not considered justifiable.

CASE XII.—A woman, aged fifty years, said that her hands had always been cold (although there were no paroxysmal colour changes), and that she had been subject to cold

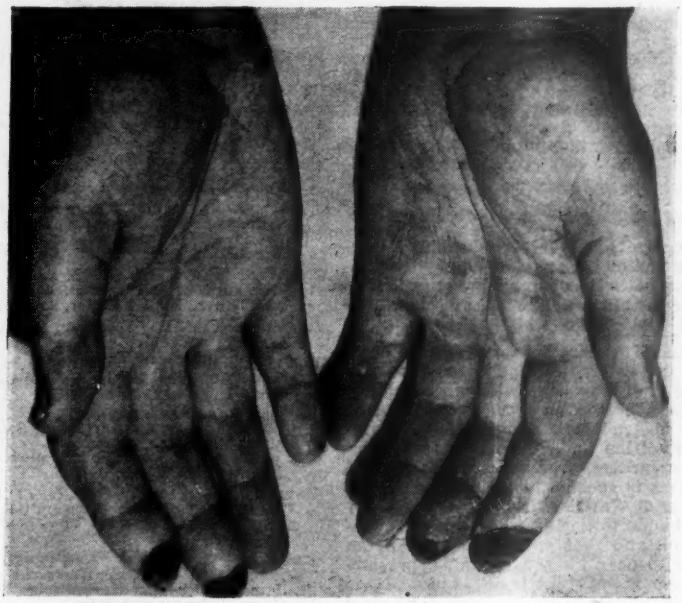

FIGURE X.
Hands of patient in Case XII.

feet since a nervous collapse some nine years previously. Six weeks prior to examination her fingers became stiff, and two weeks later the tips of the index and middle fingers of both hands became painful and then black. Apart from some nervous irritability, her general health was satisfactory. She did not smoke. The fingers were slightly cyanosed, and the tips of the index and middle fingers of both sides were gangrenous (Figure X). The radial and ulnar pulses were present. When the hands were immersed in cold water the fingers became more cyanosed, but there were no abrupt colour changes. In response to a reactive hyperæmia test flushing occurred normally to the metacarpo-phalangeal joints, but progressed slowly along the fingers. The feet were cold and slightly cyanosed, but all the lower limb pulses were present. Radiographic examination of the thoracic outlet region revealed no abnormality. There were no agglutinins or cryoglobulins in the serum. This patient's history and findings indicated simultaneous acute occlusion of the arteries of both hands.

Cervico-dorsal sympathectomy was performed, but produced no significant warming of the hand or acceleration of healing of the fingers compared to the other side. Several weeks later the patient was admitted to hospital with a febrile illness, the cause of which was not established. On one occasion blood culture yielded a growth of meningococci, although the fever did not respond to a series of antibiotic drugs usually effective against these organisms. The patient died suddenly after several weeks of fever. Necropsy did not elucidate the nature of the illness. The palmar arches and the digital arteries to the third digit of the right hand were examined. On the radial side, the arch and the digital artery were almost occluded by intimal proliferation (Figure XI). A similar, but less pronounced, process was present on the ulnar side.

Ischæmic Symptoms Following Sympathectomy.

At first sight, classification of cases of ischæmia of the hands under the heading "following sympathectomy" would seem absurd, because sympathetic nervous interruption is known to produce increased blood flow, and this operation is frequently performed for ischæmia of the hands.

The first patient[1] included under this heading had been operated on some two years previously for a probable thoracic outlet syndrome, and later cervical sympathectomy had been performed. The affected hand was cold, but there was no evidence of any obstructive arterial lesion. In the second case a similar condition had occurred in one hand after sympathectomy for cardiac pain. The mechanism of the changes in these cases is speculative. However, it has been shown (Barcroft and Walker, 1949) that the early high blood flow in the hands following cervico-dorsal sympathectomy is short-lived, and that within two weeks the blood flow has returned to near its resting value, presumably from the development of "intrinsic" tone. It is conceivable that this development of intrinsic tone may sometimes be excessive, so that the blood flow in the sympathectomized hand is reduced below that of the other hand.

SUMMARY AND CONCLUSIONS.

1. Occlusive arterial disease has a more varied picture in the upper than in the lower limbs.

2. Classification is made difficult by the confusion in terminology which still exists. The definition of the terms "Raynaud's disease" and "Raynaud's phenomenon" is discussed.

3. Tests useful in investigating occlusive arterial disease in the upper limbs are described.

4. Thirty patients with occlusive arterial disease of the hands are classified on a clinical basis.

5. "Raynaud's disease", in the sense in which this term is now used—to imply a functional vasospastic disturbance of the circulation to the extremities not secondary to some other disease—accounts for a minority of the cases. In the remainder, there is a discoverable "cause" or evidence of structural arterial disease.

6. Illustrative case histories are given of the various conditions listed in the classification.

[1] It is intended to describe these two cases in more detail later.

ACKNOWLEDGEMENTS.

My thanks are due to Dr. T. E. Lowe, Director of the Baker Medical Research Institute and Clinical Research Unit, Alfred Hospital, for helpful criticism in the preparation of this paper, to physicians and surgeons of the Alfred Hospital who referred patients, and to Dr. H. C. Trumble for the operative findings. Arteriographic studies were performed by Dr. B. L. Deans and Dr. H. Luke, of the radiological department of the Alfred Hospital. The pathological study and photomicrography in Case XII were carried out by Dr. A. V. Jackson, pathologist to the Alfred Hospital. The other photography is the work of Mr. T. O'Connor, clinical photographer to the Alfred Hospital.

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Legends to Illustrations.

FIGURE V.—Lateral X-ray picture of cervical part of spine in Case VIII, showing osteophytes and narrowing of disk spaces (especially between fifth and sixth and between sixth and seventh cervical vertebræ).

FIGURE XI.—Histological section of digital artery, Case XII.

Reports of Cases.

AN UNKNOWN GASTRIC LESION.

By W. MAXWELL,

Sydney.

A FEMALE PATIENT, aged seventy-seven years, sustained a fracture of the right forearm in February, 1952. Several weeks later, while still in hospital, she had an acute attack of severe substernal pain which radiated to the right hypochondrium. It lasted several hours until relieved by an "injection". This pain has since recurred on several occasions, and has been unrelated to exertion or meals. There was an especially severe attack in November, 1953.

On presentation, the patient had had anorexia and had lost much weight in the last year, and could not tolerate meat or fat. She had also had many vomiting attacks without any pain; she had had no dyspnœa or œdema. She had been treated for "blood pressure" in the country, and because of this and the substernal pain I referred her to Dr. Brian Haynes. He found her blood pressure to be 220 millimetres of mercury, systolic, and 110 millimetres, diastolic, and the apex beat to be just outside the mid-clavicular line. A grade I systolic murmur was present at the mitral area. There was no tenderness over the gall-bladder. An electrocardiogram showed a unifocus ventricular extrasystole every ten to twenty beats. There was no evidence of left ventricular strain or past myocardial infarction. X-ray examination with a barium meal revealed no abnormality in the stomach or duodenum; but three large gall-stones were present.

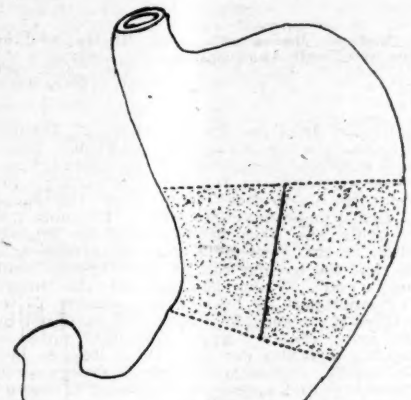

FIGURE I.

On the patient's being returned to me, and because I was impressed with her obvious loss of weight, I had a barium enema X-ray examination and a blood urea estimation carried out. It appeared that the enema was held up at the hepatic flexure; the blood urea content was 68 milligrammes per 100 millilitres. A fractional test meal examination was not made, as the patient—a private one—and her relatives were anxious for operation; the old woman said she would accept the definite operative risk as the pain was unbearable.

Operation was performed on September 29, 1954, the primary objective being cholecystectomy. The gall-bladder appeared normal, but contained three stones of moderate size. The ascending colon and hepatic flexure were normal, so I inspected the stomach. Here at once I came upon a lesion whose appearance was quite unfamiliar to me. Its situation and extent are shown in Figure I. There was a red, inflammatory thickened area similar in appearance to that over and around an acute peptic ulcer. It occupied the middle third of the anterior wall of the stomach with sharply defined upper and lower borders. The whole of the posterior wall of the stomach was normal in appearance, and there were no glands involved. A longitudinal incision was made into the stomach in the position shown by the straight line in Figure I. The wall was almost a centimetre in thickness, and of a rubbery consistency. The mucosa deep to the lesion appeared to have been uniformly superficially eroded, and the rugæ were rigid and much thickened. The rugæ of the posterior stomach wall within reach had a similar appearance. A small piece of stomach wall was removed for biopsy.

At this stage the anæsthetist advised expedition, so I was unable to obtain a photograph. The gall-bladder was removed.

Dr. A. H. Tebbutt reported as follows on the specimen: "Sections show the plain muscle of the stomach wall, and towards the inner side much fibrosis and inflammatory infiltration, the cells being polymorphs, also eosinophils, histiocytes etc." He could not name the condition, but there was no evidence of malignant disease.

Figure II is a microphotograph of the serosal half of the stomach wall; Figure III shows the mucosal part.

The patient died precipitately twenty-eight hours after operation; Dr. Brian Haynes believes death to have been due to cardiac failure.

Was this an unusual type of inflammatory *linitis plastica* with an atypical site? Was the condition responsible in whole or in part for the patient's pain and loss of weight? On histological grounds it is certainly not a chronic gastritis.

Acknowledgements.

I am indebted to Dr. Brian Haynes and Dr. A. H. Tebbutt for their assistance in the investigation of this patient, and to Sister M. Regius, of Saint Vincent's Hospital, for the illustrations.

Legends to Illustrations.

FIGURE II.—Stomach, serosal surface (×120).

FIGURE III.—Stomach, mucosal surface (×120).

Reviews.

Heart: A Physiologic and Clinical Study of Cardio-vascular Diseases. By Aldo A. Luisada, M.D., with a foreword by Herrman L. Blumgart; Second Edition; 1954. Baltimore: The Williams and Wilkins Company. Sydney: Angus and Robertson, Limited. 10″ × 7″, pp. 694, with 312 illustrations. Price: £8 1s. 3d.

THE first edition of this text-book on the heart was reviewed in this journal in terms of high praise on October 8, 1949. A second edition has now appeared, of which the title page indicates that the author is now Associate Professor of Medicine and Director of the Division of Cardiology at the Chicago Medical School and Chief of Cardiac Clinics at the Mount Sinai Hospital of Chicago. The second edition appears to have been thoroughly revised and maintains the excellence of the first, and it may be doubted whether there is any work on general cardiology which is more comprehensive, informative and succinct.

In some sections of the book succinctness is possibly overdone, and some of these are the sections to which the most frequent reference is likely to be made. The treatment of infarction of the heart is somewhat baldly stated. In a rather unhelpful section the author seems to avoid expressing any opinion of his own about the treatment of *angina pectoris*. The section on the effort syndrome still seems to lack authority and conviction. A fault of the book is the recommendation of common drugs by proprietary rather than by pharmacopœial names in the appendix devoted to prescriptions: in some cases the product of a particular distributor is specified. This is, surely, incompatible with the high standing of the publishers; besides, some of the preparations are not well known outside the United States. Another appendix contains some diets for ambulatory patients, which show that the author is ready to act on the belief that the prevention of coronary heart disease involves the "avoidance of high-caloric, high-fat diet throughout maturity".

The Hæmolytic Anæmias: Congenital and Acquired. By J. V. Dacie, M.D. (London), M.R.C.P. (London); 1954. London: J. and A. Churchill, Limited. 9″ × 6″, pp. 536, with 98 illustrations. Price: 50s.

How exciting it is, and indeed how privileged we are to live in an age of medical discovery—the sulphonamides, the antibiotics, and now ACTH and cortisone! Intermingled

with this famous company we must call to mind the recent advances in our knowledge of the hæmolytic anæmias, and the leading role played by Dr. J. V. Dacie, of the Postgraduate Medical School, London.

We now welcome Dacie's most excellent medical classic, "The Hæmolytic Anæmias: Congenital and Acquired". The author first describes "the general features of increased hæmolysis", emphasizing the significance of hyperbilirubinæmia, excess fæcal excretion of urobilinogen, changes in the morphology of the red cells and their resistance to artificial stresses, and lastly the presence of antibodies in the patient's serum.

The morphology of the red cells is of such basic importance that it is used as the main feature for subdividing the two major groups of hæmolytic anæmia—"congenital" and "acquired". Thus in the congenital group Dacie tells us of "hereditary spherocytosis", "hereditary elliptocytosis", "congenital non-spherocytic hæmolytic anæmia", and "sickle cell disease". The clinician is encouraged to obtain a detailed history from the patient, with special reference to the possible part played by drugs, infection, or associated diseases such as malignant disease; and further he is encouraged to work closely with the pathologist in elucidating the presence and nature of hæmolytic anæmia, and in determining its response to treatment be it the administration of cortisone or ACTH, blood transfusion or splenectomy.

A warning is issued regarding the giving of massive blood transfusion in the idiopathic acquired group, as the transfused cells may undergo rapid hæmolysis. In this group one would like to have heard more from the author regarding the relative values of ACTH, cortisone, blood transfusion and splenectomy, and we hope that accumulating experience will soon encourage him to give us a further volume on treatment.

We heartily congratulate Dr. Dacie on the excellence of this publication. It will be a text-book for every hæmatologist and clinical pathologist, and it will serve as a most valuable reference book for all clinicians.

Rh-Hr Blood Types: Applications in Clinical and Legal Medicine and Anthropology: Selected Articles in Immunohematology. By Alexander S. Wiener, M.D., F.A.C.P.; 1954. New York: Grune and Stratton. 10" × 7", pp. 775, with about 150 text figures. Price: $11.50.

THIS imposing volume, entitled "Rh-Hr Blood Types: Applications in Clinical and Legal Medicine and Anthropology", by Alexander S. Wiener, is a collection of selected articles in immunohæmatology. These articles, by Wiener or by Wiener and his collaborators, have all appeared in various journals during the past 15 years. They are printed in full with titles and bibliographies, so that the book is actually a bound volume of reprints arranged so as to tell the story of the Rh factor. They are not in strict chronological order, for some are reviews and are fitted into the sequence according to the events they record rather than to the date of their publication. Thus the first reprint is an appreciation of the life and work of Karl Landsteiner, reprinted from the *Current Medical Digest* of August, 1951, and the second "A History of the Rh-Hr Blood Types" from the *Journal of the History of Medicine and Allied Sciences*, 1952. The frontispiece is a photograph of Wiener's great teacher and collaborator, Karl Landsteiner, discoverer of the "A B O" blood groups and co-discoverer with Wiener of the Rh factor. Their short but epoch-making paper, entitled "An Agglutinable Factor in Human Blood Recognised by Immune Sera for Rhesus Blood", published in 1940, follows the two introductory papers and is followed in turn by another historic paper, "Hæmolytic Reactions following Transfusions of Blood of the Homologous Group, with Three Cases in which the Same Agglutinogen was Responsible", which appeared in *Annals of Internal Medicine* (1940) and which records the original flash of thought linking the Rh factor with transfusion reactions. There follows, as number 6, "A New Test (Blocking Test) for Rh Sensitization"; this discovery, too, must be accredited to Wiener. So far, so good, but as the series proceeds the story becomes one-sided. The discovery of the Rh factor can certainly be told as the work of Landsteiner and Wiener and (to a lesser degree) Peters, but the story of its development since 1940 belongs to many workers.

Once the fundamental work had been done—and it should be remembered that the discovery of the Rh factor was not merely a lucky chance, but the outcome of Landsteiner's conviction that there were individual differences in human blood, and of much patient and laborious work by himself, by Wiener and others—the idea was taken up by workers in many fields all over the world. It now belonged not to its discoverers, but to humanity, and it seems unwise to record the story of its development in terms of the work of one man or even of one school of thought. The papers collected here refer, of course, to the work of innumerable authors, but this work is always interpreted according to Wiener. However, it is an interesting and indeed a monumental record of Wiener's share in the development of the Rh idea and sets out in full his arguments for the retention of the original nomenclature as opposed to the C.D.E. nomenclature introduced by Fisher later. No less than 84 papers by the Wiener school are reprinted here—no mean achievement for one man and his associates in 14 years. This is not, however, the sum total; for the author's bibliography, included in this book, is a list of 333 publications, appearing during the years 1929 to 1953. This collation of reprints is in a sense an apologia; no one would deny the outstanding value of Wiener's pioneering work in this field, but much of his later work has been controversial, even polemical, and in this book, with its recurring headlines, he seems to throw down the gauntlet, determined to make a tournament on the open field of science. It is a pity that so great a man should take this attitude.

Modern Medical Monographs: An Rh-Hr Syllabus: The Types and Their Applications. By Alexander S. Wiener, M.D., F.A.C.P., F.C.A.P.; 1954. New York: Grune and Stratton. 9" × 5½", pp. 94, with nine illustrations. Price: $3.75.

THIS "Rh-Hr Syllabus" by Alexander S. Wiener is one of the series "Modern Medical Monographs" published by Grune and Stratton, New York. It is a small, slim volume, the purpose of which, as stated in the author's preface, is "to present an up-to-date summary of the subject in a compact, easily understandable form". To quote the preface further: "This has been accomplished by presenting the information in the form of a glossary, arranged in logical order, so that the booklet can be read through readily from beginning to end". Wiener has used only the "international" Rh-Hr nomenclature, as he is firmly opposed to the C.D.E. nomenclature introduced by Fisher and favoured by Fisher, Race and many others. Apart from this omission—and it is a very big omission, for even those who do not care to use the C.D.E. nomenclature must recognize its place in the literature and appreciate the work of those who use it—this primer provides a useful summary of a complex subject and is recommended by its author as an introduction to his other books, namely, "Blood Groups and Transfusion" and his recently published collection of his own reprints "The Rh-Hr Blood Types", reviewed above.

Textbook of Operative Surgery. By Eric L. Farquharson, M.D., F.R.C.S. (Ed.), F.R.C.S. (England); 1954. Edinburgh and London: E. and S. Livingstone, Limited. 10" × 6½", pp. 862, with 623 illustrations, a few in colour. Price: 75s.

THIS book is well written and well illustrated, and its production does credit to its publishers. But there are errors, a few of which may be mentioned.

Splinting fingers in full extension is not necessary after suture of an extensor tendon. It may lead to permanent stiffness. Yet this method is recommended in Figure 35. Later, Figure 162 is introduced to condemn it.

The old-fashioned Kanavel method of treating finger-pulp infections is still recommended, although it has been shown, as by Newton and Claffey, that with antibiotics more gentle surgery will suffice. In the chapter on hand and fingers, under the sections dealing with general considerations and injuries, in the rules for the management of plaster casts, and under the general treatment of infected wounds, we find no mention of that simple and most important method, "elevation of the part above heart level". The rule for amputations, that "the end of the bone should be covered with skin and subcutaneous tissue alone", should be more precisely specified to include deep fascia.

In spite of the work of J. E. Fraser, later confirmed radiologically, we find the thyro-glossal tract behind or in the hyoid bone.

Reliance on enucleation and radiotherapy for mixed parotid tumours is ill-founded.

In the chapter on the breast, the Wakeley method of detecting a duct-papilloma by passing a needle through the nipple is not likely to impress the surgeon, in spite of the large diagram devoted to it.

In the diagnosis of carcinoma, it is highly inadvisable to cut into the tumour and proceed with radical mastectomy. The incision cannot be hermetically sealed and the display of cut surface is restricted.

In the treatment of intussusception, Clubbe's method of fluid injection is not even mentioned.

Writing of "Paralytic Ileus", Farquharson recognizes that the condition is usually peritonitis. It would therefore be wise to call it peritonitis. The rare distension due to other causes could then be called "distension due to other causes", the cause being specified. There was some excuse for the indefinite term in the days of Sydenham, but not nowadays. A spade should be called a spade.

In gastric surgery the eponyms are hopelessly mixed, and historical justice is not done.

The layers of the hydatid cyst are wrongly named.

In jaundice, "glucose solution with some preparation of vitamin *K* should be administered intravenously". Why intravenously? What preparation? What dose?

It is not clear why the patient suffering from acute pancreatitis should be loaded with the extra hazard of double-tube drainage of the pouch of Douglas.

Non-crushing clamps are still used for end-to-end intestinal anastomosis, although these do more harm than good, except perhaps in acute obstruction of the small bowel. It is better to hold the bowel with a crushing clamp at its end and remove this, and the crushed tissue, when the posterior suture layer is completed.

After abdominal operations, "normal bowel function may be attained in 2 or 3 days without aperients. A mild aperient may however be prescribed as a routine". A principle is thus established from observation, and immediately compromised from tradition. For the resulting colic, an enema is then prescribed, and pethidine is not mentioned.

This book can be recommended to the discriminating post-graduate student. Its errors are not more numerous than those in other text-books of surgery.

The Study of the Brain: A Companion Text to the Stereoscopic Atlas of Neuroanatomy. By Hyman S. Rubinstein, M.D., Ph.D., D.A.B.P.N., F.A.P.A., with a foreword by Carl L. Davis, M.D.; 1953. New York: Grune and Stratton. 11" x 8", pp. 222, with 137 illustrations, one in colour. Price: $9.50.

THIS volume is certainly less formidable in bulk and scope than most modern works on neuroanatomy and is thus likely to make an initially greater appeal to the harassed student of today. On analysis it is found to cover most of the ground covered by more pretentious books, but in a rather sketchy synoptic fashion, which necessarily imparts a tone of instruction more dogmatic than our knowledge at present warrants. Moreover, this kind of treatment inevitably tends towards a rather catalogue-like monotony, useful enough for learning by rote but devoid of anything likely to convey even a fair understanding of the subject. Any compilation of this sort is, of course, bound to contain statements with which any expert is certain to disagree and no useful point is served in elaborating them. But there are errors of fact also—for example, the assertion that the *striæ medullares* of the fourth ventricle form part of the acoustic pathway—and these could be corrected. The illustrations, on the whole, are disappointing. They nearly all contain too much detail for the size of reproduction and are more confusing than instructive. However, the title page describes this as "A Companion Text to the Stereoscopic Atlas of Neuroanatomy" (by Rubinstein and Davis); since we are unfamiliar with the Atlas it is probably unfair to assume that the figures in the book are all that the student has to guide him. We sympathize strongly with any attempt to reduce the bulk of matter the student is expected to learn, but we do not feel that in achieving that objective the author has here succeeded in really lightening the student's task. The book is well bound and produced, but is a little large for convenient transport to and from classes.

The Clinical Examination of the Nervous System. By G. H. Monrad-Krohn, M.D., F.R.C.P.; Tenth Edition; 1954. London: H. K. Lewis and Company, Limited. 8½" x 6", pp. 448, with 165 illustrations. Price: 36s.

THIS book is now in its tenth edition, thirty-three years since it was first published. Changes in the book have been by way of addition rather than by alteration, though several sections have been rewritten, including that on consciousness in which the role of the reticular substance in the brain stem is discussed at some length. The surface markings of the cranial vault have received special attention, with three new figures. There is no reference to Leksell's apparatus and technique for localization in stereoencephalotomy, probably regarded as too specialized for ordinary clinical examination. Aphasia has been elaborated with the addition of a section on amusia. More might have been said about alexia. Electroencephalography and electromyography are described at the end of the book instead of earlier, as is the case also with the chapter on simulation and aggravation. The difficulty of describing adequately tremors and other abnormal movements is met by the use of a special portable kinematograph. The pharmacodiagnosis of disorders of the vegetative system is reviewed in seven pages. The author continues to rely on the Binet-Simon scale of tests of intelligence.

This work in its successive editions is becoming a compendium of clinical tests, which runs the risk of confusing the beginner, but which may prove less than adequate for the more experienced clinician. The format of the book is greatly improved by the larger size of pages which have increased in number from 428 to 459, with thirty more illustrations. This new edition is assured of the favourable reception accorded to its predecessors.

The Child, His Parents and the Nurse. By Florence G. Blake, R.N., M.A., with a foreword by Adrian H. VanderVeer, M.D.; 1954. Philadelphia: J. B. Lippincott Company. Sydney: Angus and Robertson, Limited. 9½" x 6½", pp. 458, with one illustration. Price: 53s. 9d.

FEW will deny that basic knowledge about the essential emotional needs of the child is curiously lacking and slow to be accepted amongst those professions dealing with the growth and development of young children.

Slowly we are appreciating the significance of the whole child in health and sickness, and the importance of the part played by nurses, doctors, teachers *et cetera* in the promotion of mental health in the community can be considerable.

Miss Blake's book deals with the important role played by the nurse in this respect, not only in dealing with the child, but in helping to prepare the expectant mother for a satisfactory relationship with her babe-to-be.

The book details the types of reactions to be expected at various age levels from children separated from the security of their homes and entering hospital. All types of experiences are listed from the child's reaction to frequent penicillin injections, to his response to painful operations and impending death. The nurse is urged to discover why the child reacts as he does. This she accomplishes by patient questioning or simply by friendly advances and waiting. The method is an admirable one, but seems far from attainment in a nursing world so universally short staffed, and apparently so busy with modern techniques.

The author urges that the child should be admitted, not to a ward or unit, but to a nurse. This attitude of case assignment, rather than work assignment, is highly desirable and necessary.

It would be useful for the student nurse to have some of the phenomena of children's behaviour explained to her before she is presented with bewildering situations in the ward, but we do not consider that this book is the ideal for the beginner. It lacks conciseness and is often confusingly repetitive; clearer tabulation of the reactions of certain age levels is desirable; also there is an acceptance of certain controversial Freudian theories without comment, which both newcomer and more experienced reader might find unacceptable.

The book is readable and interesting throughout, and while one cannot agree with all Miss Blake's ideas, all persons dealing with children in hospital, whether they be nurses, doctors, dentists, social workers or teachers, would do well to read the book. It should be especially valuable to sisters in charge of pædiatric wards, and directors of schools of nursing.

Emergency Treatment and Management. By Thos. Flint, junior, M.D.; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. 9½" x 6½", pp. 314. Price: £2 14s. 9d.

THE medical emergency situation frequently has to be managed by the more inexperienced and junior members of the profession. The line of action adopted at this stage can determine the whole course of the illness. In addition emergency cases may be associated with medico-legal problems such as compensation claims for injury, criminal actions and charges of negligence.

This book is divided into three main sections: 1, "General Medical Principles and Procedures"; 2, "Emergency Treat-

ment of Specific Conditions"; 3, "Administrative Clerical and Medico-Legal Procedures". Such matters as management of patients dead on arrival, rape cases, serum desensitization, tetanus immunization, and advisability of the X-ray examination of all bone injuries are considered in the first section on general medical procedures. The "Emergency Treatment of Specific Conditions" makes up the main body of the book and includes 114 subjects. There is a useful and rather comprehensive section on the treatment of poisons and another on wartime emergencies. Dr. Flint considers that political and social unrest justify its inclusion of the latter at this time. The greater part of the book is written in the tabular and summary form and is well indexed so that one can easily find the required section. The information given is helpful and reliable.

This would be a useful book for the young doctor commencing his term as a casualty surgeon or embarking on general practice or for any doctor who has to deal with occasional emergencies.

Office Gynecology. By J. P. Greenhill, B.S., M.D., F.A.C.S., F.I.C.S.; Sixth Edition; 1954. Chicago: The Year Book Publishers, Incorporated. 8" x 6", pp. 517, with 127 illustrations. Price: $7.75.

SOME of the procedures in this book would be considered beyond the scope of office gynæcology in Australia, but the greater part of the work is devoted to problems commonly encountered by the practising gynæcologist, but seldom discussed in standard text-books on the subject.

Psychological disorders are described in the chapters on psychosomatic gynæcology, dyspareunia and frigidity and the menopause. The excellent chapter on premarital advice is again included.

In the field of infertility there are good chapters on sterility, Rubin's test and hysterosalpingography. Present methods of determining whether ovulation takes place are carefully assessed. The technique of artificial insemination is described in detail. Indications for the use of semen of husband, donor and a mixture of both are thoroughly discussed, with a brief account of the present legal position. Two chapters describe fully current methods of control of conception by mechanical and "safe period" techniques.

Endocrine aspects of gynæcology are adequately covered in four chapters which include normal and abnormal menstruation and the menopause. Methods of hormone administration are suggested and their limitations discussed.

The diagnosis of uterine cancer is dealt with in chapters on cervical smears, the Schiller test and invasive carcinoma of the uterus. In another useful chapter helpful measures for the relief of severe pain in late carcinoma of the genital tract are detailed.

Interesting new fields in gynæcology are surveyed in chapters on culdoscopy, post-partum care and the value of pelvic floor exercises in genital relaxation and early stress incontinence.

Chapters on examination of the breast, office urology, office proctology and obesity give worthwhile information on frequently encountered problems which are not strictly gynæcological.

Unfortunately, Greenhill does not reduce the present diagnostic confusion in his chapter which deals with the conditions of *kraurosis vulvæ*, *leucoplakia vulvæ* and chronic atrophic dermatitis of the vulva. However, a good comprehensive account of a miscellaneous group of conditions, including chapters on vulvitis, vaginitis, cervicitis, gonorrhœa, pelvic tuberculosis, and cysts and abscesses of Bartholin's gland comprises the remainder of the book.

Here then is a clearly written and abundantly illustrated book which can be recommended as a useful complementary work to the standard gynæcological text-books. Not all the methods described are in line with Australian practice, but most of the ideas are worthy of serious consideration and all the methods described are completely practical.

Having a Baby. By J. F. Robinson, M.B., Ch.B.; 1954. Edinburgh and London: E. and S. Livingstone, Limited. 7½" x 5", pp. 100, with 23 text figures. Price: 6s. 6d.

THIS is an admirable little book, the main aim of which, as stated in the preface, is "to help expectant mothers to understand what is required of their bodies during pregnancy and labour". It covers all aspects of pre-natal and post-natal periods, discussing such topics as diet, care of the teeth, care of the nipples and general hygiene. The importance of proper exercises during pregnancy is stressed and a series is described. An all-too-brief chapter is devoted to infant feeding. The book also deals with what the author terms the "plain facts of married life"; under this heading the various methods of contraception aimed at spacing a family are detailed. Throughout the book well-drawn sketches are present to illustrate the text more than adequately.

All parents-to-be can be recommended to read this clearly and happily written book.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Standard Values in Nutrition and Metabolism: Being the Second Fascicle of a Handbook of Biological Data", edited by Errett C. Albritton, A.B., M.D.; 1954. Prepared under the direction of the Committee on the Handbook of Biological Data, American Institute of Biological Sciences, The National Research Council. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. 11" x 9", pp. 394. Price: £3 1s. 9d.

The monograph is the product of contributions of more than 800 specialists in the fields of nutrition and metabolism.

"Textbook of the Rheumatic Diseases", edited by W. S. C. Copeman, O.B.E., M.D., F.R.C.P.; Second Edition; 1955. Edinburgh and London: E. and S. Livingstone, Limited. 9½" x 7", pp. 762, with 464 illustrations, a few in colour. Price: 52s. 6d.

The first edition was published in 1948 before the introduction of cortisone, hydrocortisone and ACTH.

"The Practice of Mental Nursing", by May Houliston, R.G.N., R.M.N., R.F.N., with a foreword by P. K. McCowan, J.P., M.D. (Edin.), F.R.C.P. (London), D.P.M., Barrister-at-Law; Second Edition; 1955. Edinburgh and London: E. and S. Livingstone, Limited. 7½" x 5", pp. 176. Price: 7s. 6d.

Written primarily for the junior student nurse, but intended for any nurse in a mental hospital.

"Pediatric Diagnosis", by Morris Green, M.D., and Julius B. Richmond, M.D.; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. 10" x 7", pp. 454, with eight text figures. Price: £4 15s.

The aim of the authors is to help students and practitioners in diagnosis.

"The Surgical Clinics of North America"; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. Philadelphia number. 9" x 6½", pp. 298, with 65 illustrations. Price: £6 *per annum* with paper binding and £7 5s. *per annum* with cloth binding.

There are 27 authors. The number consists of a symposium on gynæcology and obstetrics. There is an additional article on prostatectomy.

"Artificial Respiration: With Special Emphasis on the Holger Nielsen Method", by T. O. Garland, M.A., M.D., D.P.H.; 1955. London: Faber and Faber, Limited. 9" x 5½", pp. 60, with 27 illustrations. Price: 6s. 6d.

The illustrations in the book are an important feature.

"The Parents' Book: A Guide to Mothercraft", by Margaret H. Harper, M.B., Ch.M., F.R.A.C.P., and Kathleen Winning, M.B., Ch.M. (Sydney), D.C.H. (London); Twentieth Edition; 1955. Sydney: Angus and Robertson, Limited. 7½" x 5", pp. 110, with 12 illustrations. Price: 9s. 6d.

Published under the auspices of the Royal Society for the Welfare of Mothers and Babies.

"Amphetamine in Clinical Medicine: Actions and Uses", by W. R. Bett, M.R.C.S., L.R.C.P., F.R.S.I., Leonard H. Howells, B.Sc., M.D., F.R.C.P., and A. D. Macdonald, M.A., M.D., M.Sc.; 1955. Edinburgh and London: E. and S. Livingstone, Limited. 7½" x 5", pp. 84. Price: 7s. 6d.

Intended as a guide to the general practitioner.

The Medical Journal of Australia

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All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of the article. The abbreviations used for the titles of journals are those adopted by the Quarterly Cumulative Index Medicus. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

NOBLESSE OBLIGE.

THE term *noblesse oblige* is of ancient and somewhat obscure origin. The sentiment behind it was used by Æschylus and has been translated as "relationship compels". Boëthius declared that if there was any good in nobility it could only be that it imposed on those who were noble that they should not suffer their nobility to degenerate from the virtues of their ancestors. The French saying was held by the Comte de Laborde to have been used first by Duc de Levis in 1808. Although its original use had to do with the *noblesse*, the nobility, of France, it has nowadays assumed a much wider significance. It is applied now to persons who enjoy any unusual privileges. It was used as a title for a leading article in this journal as long ago as 1927. Attempts to trace the origin of the term have revealed some interesting facts. In the eleventh edition of the "Encyclopædia Britannica" there appears an article on nobility, which strangely is lacking in the fourteenth edition. In the eleventh edition it is stated that to form a true understanding of what is strictly implied in the word "nobility", in its social as opposed to a purely moral sense, it is needful to distinguish its meaning from that of several words with which it is likely to be confounded. In England, nobility is apt to be confounded with the "peculiar institution" of the British peerage. Nobility in some shape or another has existed in most places and at most times of the world's history, whilst the British peerage is an institution which is purely local. The view is expressed that the British peerage has actually hindered the existence of a nobility in the sense which the word bears in most other countries. Nobility is not the same thing as aristocracy. The word aristocracy is often greatly abused. Whenever it is used with any regard to its true meaning, it is a strictly political word, implying a particular form of government. Nobility is not necessarily a political term; the distinction which it implies may be accompanied by political privileges or it may not. The dogmatic statement is made that there is nothing in a republican or even in a democratic form of government which is inconsistent with the existence of nobility. Aristocracy implies the existence of nobility, but nobility does not imply aristocracy. The peerage as it exists in Great Britain is something which is altogether peculiar to it, and which has nothing in the least degree like it elsewhere in the world. Gilbert and Sullivan's "Iolanthe" bears witness to this. Nobility in the strict sense of the word is the hereditary handing on from generation to generation of some acknowledged preeminence—a preeminence founded on hereditary succession and on nothing else. Nobility does not imply wealth, but "nobility without wealth runs some risk of being forgotten". It is interesting that nobility and gentry are the same thing. This fact is overshadowed in England partly by the habitual use of the word "gentleman" in various connotations, and partly by the present confusion between nobility and peerage. That nobility and gentry are the same is proved by the use of the French word *gentilhomme*, a word which has well-nigh passed out of modern use, but which, as long as it remained in use, never lost its true meaning. There were very wide distinctions within the French *noblesse*, but all those so classed formed one privileged group, as distinguished from the *roturier*. We read that the nature of nobility may differ widely according to the causes which have led to the establishment of the distinction between family and family in each particular case.

Medicine, fortunately or unfortunately, has been named as a noble profession. The term implies, generally speaking, that its members are noble because they undertake the healing of sick persons. If the members of the profession take this unction to their souls, they must recognize, as the French did many centuries ago, that *noblesse oblige*, that nobility carries with it certain obligations. We may remember that Thomas Kyd, writing in 1594 in *Cornelia*, stated: "True noblesse neuer doth the thing it should not."

The obligations of medical men and women, as members of a profession which has been styled noble, may be grouped under several headings. Thus we have the obligations of a medical man to his patients, to his colleagues, to the art and science of medicine, and to the community at large. A great deal has been written in this journal and in other places about a medical practitioner's obligations to his patients. What is necessary may be summed up in the statement that the patient must be treated as a person, and not as an example of a disease, that the treatment provided for him should be as direct and as simple as possible, and that his interests, both social and financial (as far as his illness is concerned), should always receive first consideration. S. M. K. Mallick, Dean of Dow Medical College, Karachi, in an address given to the first World Conference on Medical Education in August, 1953, stated that in spite of having gathered so much glory around it, the medical profession was never in so much danger as today. The foremost of these dangers, arising from internal causes, was the great development in

techniques and diversification of medicine into innumerable channels. He insisted that over-emphasis on technique was adversely affecting the concept of the profession, and that consideration of the patient as an individual with a peculiar environment and a particular psychic background was largely ignored. "Engrossed and enamoured with the study of the individual trees, the concept of the forest is being lost." The obligation to a brother practitioner may be summed up in the Golden Rule. If our behaviour to a brother practitioner is always the kind of behaviour that we should like to see him adopt towards us, there will be no cause for complaint. Moreover, it is wise to remember that everyone is liable to make a mistake. Today it may be the misfortune of the other man to fall into error; tomorrow it may be ourselves. We have been told that "Charity suffereth long and is kind", and if we cannot be instinctively kind, we may perhaps cultivate kindness on the less worthy ground that tomorrow we may need somebody to be kind to us. The obligation to the science and art of medicine need not be dwelt upon at any length. Many of us by careful observation, if not by experiment, are in a position to make a contribution to knowledge, and if we are not, we can at least try to make ourselves familiar with contributions made by others in the field of medicine which is of particular interest to us. Of the obligation medical practitioners owe to the community at large a great deal might be written. The whole subjects of public health and social medicine are involved. We need to remind ourselves that neither preventive medicine nor social medicine is a separate discipline with knowledge peculiar to itself. Its practice depends upon an attitude of mind as much as upon anything else. The medical practitioner practises preventive medicine in almost all his associations with a family, and as an example of social medicine in everyday medical practice we may cite the estimate which often has to be made about the effects of work on one or other members of a family. The average reader of this journal could no doubt write a satisfactory essay on the subject. Little more need therefore be added.

The old saying "*noblesse oblige*" has so far been discussed and applied to medicine and medical practitioners. It has, of course, a much wider application. Nearly every member of the community has some kind of privilege. Many may think that their privileges are obscure, but a little heart-searching will probably show that this is not a fact. The privilege may be only an opportunity to do something for somebody else, but it is none the less a privilege. Most people are able to distinguish between what is right and what is wrong, and this is a kind of *noblesse* which must not be lost sight of. This is something to which we may all turn our attention, and if we try to do this with sincerity we shall not fall into error. In his address to the conference on medical education, Dean S. M. K. Mallick quoted some lines by an Indian poet which may be used to close this discussion:

> To the hand of the diver
> The gains of the tide;
> To the eyes of the bridegroom
> The face of the bride;
> To the heart of the dreamer
> The dreams of his youth.
> For me, O my Master,
> The rapture of Truth.

Current Comment.

THE PROGNOSIS IN HODGKIN'S DISEASE.

THE difficulties in determining the prognosis in a case of Hodgkin's disease are well known. Two general statements can be made with reasonable confidence: first, the disease will sooner or later (apart, of course, from intervening fatal incidents from other causes) bring about the patient's death; second, modern treatment has modified the course of the disease in the patient's favour. Beyond this, generalizations are of limited value, although the experience of most people will be in accord with a recent summing-up of the position by Ralston Paterson and Edith Paterson.[1] They state that, clinically, both the extremes of short survival and long survival are found. Acute cases are usually atypical in that the lesions are mainly in the viscera. There is almost from the beginning a high temperature and severe prostration. In such cases, which occur generally in young people, the duration may be only a few months, and response to chemotherapy is slight. In the really chronic type of case, on the other hand, the patient may be kept in reasonable health for periods of up to and exceeding ten years, during most of which time he remains able to attend to his business.

The real difficulty, however, and the one from which the clinician is never free, is in determining the prognosis in the individual case. Some light is thrown on it in a study by J. A. Finkbeiner, L. F. Craver and Henry D. Diamond[2] of the hospital records of 1000 patients with Hodgkin's disease. From these records were selected a group of patients with an extremely rapid course and a group of long-term survivors. These two groups were compared to determine whether a patient with Hodgkin's disease when first interviewed presents clinically detectable signs that may aid in estimating the prognosis. Finkbeiner, Craver and Diamond present details of the comparative analysis of the two groups, but their general conclusion is that clinically detectable factors, namely, age, sex, race, colour, marital status, family history, personal history, extent of disease, symptoms, findings made on physical examination and the results of laboratory investigations, are not reliable prognostic signs. On the other hand, despite such unfavourable signs as generalized disease, constitutional symptoms, Hodgkin's sarcoma or an abnormal blood picture, carefully planned therapy persistently pursued may result in prolonged survivals.

Some of the detailed comments made by Finkbeiner, Craver and Diamond are of interest. They point out that while accurate tissue diagnosis is necessary for adequate evaluation of Hodgkin's disease, the diversity of the disease must be kept in mind constantly. Different lymph glands from the same patient may show wide variations in histopathological structure, and even different portions of the same gland may vary greatly in structure. If this fact is realized, one cannot accept the strict prognostic significance attributed to the tissue diagnosis by certain investigators who have emphasized that Hodgkin's paragranuloma has a relatively favourable prognosis, but that Hodgkin's sarcoma has a very poor prognosis. It is pointed out that while such a statement may be generally true, it cannot be applied to an individual case. The situation is summed up in a statement by Craver quoted from elsewhere: ". . . of bad omen, in general are . . . a biopsy diagnosis of sarcoma, provided the course within a few months reveals corresponding aggressiveness of the disease . . . and evidence of rapid advance of the disease, regardless of the histopathology of a node biopsy . . ."

Finkbeiner, Craver and Diamond then refer to the view that unicentric disease, especially when early treatment is carried out, and marked enlargement of external glands before treatment are favourable prognostic features, while disseminated disease, especially of the viscera, and inguinal node involvement are unfavourable features. Their findings are not wholly in accord with this. A majority of their long-term survivor group did not have

[1] *Brit. M. J.*, December 4, 1954.
[2] *J.A.M.A.*, October 2, 1954.

localized disease, and widespread generalized disease does not, in their experience, necessarily signify a poor prognosis; "with adequate and aggressive therapy, a certain number of long-term survivals will result". Certain of their long-term survivors also failed to comply with the view that the prognosis is poor in persons of either extreme of age. These authors refer to the fact that there is general agreement that Hodgkin's disease is more common in males than in females in all age groups, but their findings do not support reports which have indicated that the prognosis is better in women, nor were they able to find any particular prognostic significance in the findings of a blood cell count.

On the question of therapy, the authors state that the short-term survivors did not live long enough to have much treatment and they did not respond to treatment. A few of the long-term group responded dramatically to a small amount of irradiation to localized disease. However, more dramatic than this, and indeed of greater interest, is the story of a larger group, who, when they first started treatment, had generalized disease including involvement of lung, pleura, gastro-intestinal tract, skin, liver, spleen and abdominal nodes and had abnormal peripheral blood cell counts. Finkbeiner, Craver and Diamond state that after many courses of therapy applied to multiple sites for periods of up to three years the members of this group finally obtained prolonged remission of the disease and have remained happy, useful citizens.

One comment should perhaps be made. The findings of Finkbeiner, Craver and Diamond are a healthy corrective to any tendency to rely unduly on generalizations for the prognosis in an individual case. On the other hand, it must not be thought that they render quite invalid the commonly held criteria of prognosis, particularly such clinical features as those mentioned by the Patersons. The experienced clinician, when he is willing to offer a firm opinion on the prognosis in a case of Hodgkin's disease, is more likely to be right than wrong.

THE TREATMENT OF ACUTE RHEUMATIC FEVER IN CHILDREN.

LAST year we made reference in these columns[1] to a comparative study by H. B. Hauser, E. J. Clark and V. L. Stolzer,[2] in which they described the effects of aspirin, corticotropin and cortisone on the acute course of rheumatic fever in a series of 148 young adult males. Apart from the fact that aspirin brought more prompt relief from acute symptoms than the two hormones, the effect of the three drugs on the symptoms varied very little. An important general conclusion was that the overall effect of each of the drugs left much to be desired in the treatment of acute rheumatic fever. However, the report covered only a short-term study, and it was stated that the significance, if any, of the respective effects of the three drugs on rheumatic carditis could not be assessed on the data available at the time, but that the long-term follow-up study might reveal something of interest. The effect on rheumatic carditis is, of course, a most important, perhaps the most important, aspect of the question, and valuable light has been thrown on it in a report just published in the *British Medical Journal*.[3] This report, which is also being published in *Circulation* in the United States, will be available to most of our readers, but its importance justifies some reference to it here. It is based on work carried out under the admirable system used in recent years, particularly in the United Kingdom, whereby investigators in many cooperating centres have pooled their results. This method brings together a significant number of cases in a comparatively short period of time in a way that no single research centre could possibly manage. In the present case, the data were collected from many centres in both the United Kingdom and the United States of America, under the joint direction of the Rheumatic Fever Working Party of the Medical Research Council of Great Britain and the subcommittee of principal investigators of the American Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association. The report compares the effects of three drugs, ACTH, cortisone and aspirin, on the acute course of rheumatic fever in children under the age of sixteen years over a period of thirteen weeks from the start of treatment, and on the persistence and development of rheumatic heart disease over a period of one year. The records of 497 patients are presented. Each case met specified diagnostic criteria on admission to the trial, and the patients were allocated at random to treatment with one of the three drugs. Each treatment was given for six weeks according to a defined schedule, and detailed observations were continued for a further three weeks. Follow-up examinations were made at specified times after these nine weeks, and the present report extends to the examination made one year later, that is, sixty-one weeks from the start of treatment.

The study was designed to ensure a balance of cases in the three treatment groups for each centre, for the duration of illness at the start of treatment, and for the time of year when the patients were admitted to hospital. Random allocation of patients within this balanced design was relied upon to secure a reasonably equal distribution according to age, sex and severity and frequency of manifestations of disease. In 51% of cases, treatment was begun within fourteen days of the onset of the attack. In nearly two-thirds of the cases there was no history of a previous attack or evidence of preexisting rheumatic heart disease. The three forms of treatment were, therefore, tested on patients of whom a large proportion were still in the early stages of the disease and had no established heart disease. The three randomly constructed groups receiving ACTH (162 patients), cortisone (167 patients) and aspirin (168 patients) were notably alike in most respects at the start of the trial. The results of the various forms of treatment were measured in relation to separate manifestations of the disease—namely, pulse rate during sleep, erythrocyte sedimentation rate, joint involvement, chorea, *erythema marginatum*, nodules and such aspects of the status of the heart as heart size, atrio-ventricular conduction time, murmurs and, in particular, effects indicative of serious illness, congestive failure and pericarditis.

We need not go into the detailed findings here, but the report points out that there was no evidence that any of the three agents resulted in uniform termination of the disease, and with all treatments, some patients developed fresh manifestations during the course of treatment. Treatment with either of the hormones resulted in more prompt control of certain acute manifestations, but this more rapid disappearance was balanced by a greater tendency for the acute manifestations to reappear for a limited period upon cessation of treatment. Treatment with the hormones also led to more rapid disappearance of nodules and soft apical systolic murmurs. However, at the end of one year there was no significant difference between the three treatment groups in the status of the heart.

The comment is made in the report that the analysis of the effects of the drugs on carditis, while undoubtedly most important, is especially difficult, and the conclusions are the least clear. However, certain conclusions are regarded as being justified. First, there appeared to be no relationship between the treatment given and the behaviour of congestive failure and pericarditis. Second, there was more frequently an increase in heart size in each of the hormone groups as compared with the aspirin group. Reasons are suggested for this but are not pressed, and it is clear that at the one year follow-up examination there was no appreciable difference between the three groups. Third, the appearance for the first time of apical systolic murmurs was infrequent in all three treatment groups and unrelated to therapy. No consistent difference was noted in the behaviour of murmurs present at the start of treatment except that the soft apical systolic murmurs disappeared more rapidly in hormone-treated

[1] M. J. AUSTRALIA, July 24, 1954.
[2] *Am. J. Med.*, February, 1954.
[3] *Brit. M. J.*, March 5, 1955.

groups. Here again, at the end of one year no significant difference remained. Fourth, the *P-R* intervals in electrocardiograms decreased more frequently and more rapidly in the hormone groups than in the aspirin group. This difference between the groups lessened during the observation period and was absent at the end of nine weeks and one year. It is pointed out that since the values at these later times may be closer to normal than those recorded during acute illness, it may be questioned whether the early decrease is an effect of the hormones on the disease or merely a direct effect on atrioventricular conduction time. Fifth, at the end of one year the proportion of patients with residual cardiac damage was similar in the three treatment groups. There the matter apparently stands. It has been taken a further important step forward by this report, but a follow-up period of even one year is short for the cardiac complications of acute rheumatic fever, and it is to be hoped that the report will have sequels over many years to come.

THE DEATH OF ONE JOURNAL AND THE BIRTH OF ANOTHER.

WIDESPREAD SORROW will be expressed at the announcement that the *Edinburgh Medical Journal*, which has appeared continuously since 1805, has gone out of existence. The journal, in its announcement of the fatality, states that the event is a "geriatric casualty of the changed conditions in which we live". Unfortunately, events such as this are all too common nowadays when the costs of production are continually mounting. Several scientific societies in this country have had to relinquish publication of their journals because their funds were not sufficient to pay for printing and publication. This is the reason for the disappearance of the *Edinburgh Medical Journal*. We read that the costs of production, chiefly wages, have been rising ever since the last war, that the circulation has not increased sufficiently to offset these costs, and that advertisers seem to be concentrating more and more on postal communications. The forerunners of the *Edinburgh Medical Journal*, which is stated to have been the first effort at medical journalism in Edinburgh and among the very earliest examples of such enterprises in the United Kingdom, were the famous *Medical Essays and Observations* which appeared from 1733 to 1744. These were followed successively by *Essays and Observations, Physical and Literary*, 1745 to 1765; *Medical and Philosophical Commentaries*, 1773 to 1793; and *Annals of Medicine*, 1796 to 1804. The last-mentioned of these, which was edited by Andrew Duncan and his son Andrew, became in 1805 the *Edinburgh Medical and Surgical Journal*. The two words "and Surgical" were dropped in 1855. Since 1908 the *Edinburgh Medical Journal* has been the property of a limited company of medically qualified persons with a small authorized capital of £2000 in one shilling shares. We can well understand that cumulative losses of the last few years have completely exhausted the company's reserve funds. The directors believe that they can no longer continue to spend the shareholders' money when there is no recognizable prospect of improvement, and they wish to give up business while they are still able to pay their debts. Notification of the proposed cessation was given a year ago to the Medico-Chirurgical and Obstetrical Societies of Edinburgh, whose transactions have appeared in the *Edinburgh Medical Journal* from month to month. In the interval, efforts have been made to devise a method of continuing the journal, either in its present form or as a national Scottish journal. So far, no firm decision has been reached and the end has come. The medical societies of Edinburgh and of Scotland must be presumed to know their own business best, but people elsewhere will be keenly disappointed and will perhaps be forced to conclude that there is no will to keep the journal going. At the obsequies of this one hundred and fifty year old publication, medical people in other parts of the world can do nothing but sing its praises and remember the many important contributions which have seen the light in its pages. Even if the learned medical societies of Scotland can contrive at this very late stage to reestablish an Edinburgh medical journal the event will be a resurrection and not a continuance, but that would be better than total obliteration. The best we can hope is that this will happen.

The new journal which has been born is *The Central African Journal of Medicine*. The establishment of this journal is the direct result of the creation of a new State in central Africa. Rhodesia and Nyasaland have become federated, and the Prime Minister of the new federation, Sir Godfrey Huggins, C.H., K.C.M.G., F.R.C.S., M.P., writes a foreword to the journal. He believes that the medical profession in the federation should be able to support a journal. There are in the area a number of men and women of great ability and experience. He explains that the Board of the journal does not wish to run the journal indefinitely. It wishes to show that the creation of the journal can be a success, and they have provided in their constitution that it can be handed over to an approved body within the federation. Any profits resulting from the publication of the journal could, Sir Godfrey Huggins writes, be devoted to no better object than those which the editorial board has in mind—the founding of a library in the proposed medical faculty of Rhodesia University and the establishment of an interim reference library. The President of the Royal College of Physicians of London, Sir Russell Brain, sends a message to the first number and points out that the editor of such a journal as *The Central African Journal of Medicine* will be primarily concerned with presenting new knowledge "in such a way that it may prove catalytic in evoking new combinations of ideas in its readers". The Secretary of Health of the Federation of Rhodesia and Nyasaland, Dr. R. M. Morris, also sends a message. The first issue contains an editorial on David Livingstone and original articles devoted to obstetrics in the African, orthopædic aspects of brucellosis, a comparison between Heaf and Mantoux tuberculin tests, njovera and radioactive isotopes. In a special section there is the first part of an article on the fevers of Africa, dealing with bilharzial fever. There is also an account of the proceedings of the Medical Council of Southern Rhodesia and of the annual congress of the Southern Rhodesian Medical Association. The medical profession in Australia will wish every success to those who are launching this journal. It should serve a useful purpose.

FRACTURES OF THE CARPAL NAVICULAR.

"EVERY severe sprain or injury in the region of the carpal navicular should be considered a fracture until proved otherwise." So writes Marcus J. Stewart,[1] laying down the first principle of the management of this troublesome fracture. It is probable that the results of treatment of the fractured navicular are not, in general, as they should be; so Stewart's experience in personal observation of 436 such fractures can be heeded with profit. He summarizes his experience with this large series by stating that the results obtained substantiate good orthopædic teaching that, if a fracture of the carpal navicular is accurately reduced and adequately immobilized for a sufficient time, solid bony union may be expected. He considers that failure to diagnose, to reduce and to immobilize these fractures properly is directly responsible for delayed union or non-union. In delayed treatment, the presence of vacuolation or cystic change is not considered discouraging; "when the fracture has been properly immobilized, the healing which takes place in the cystic area will include the fracture line". Stewart believes that if the proximal fragment is viable, sclerosis at the site of fracture is no contraindication to prolonged immobilisation. As a rule, according to his experience, after two or three months of uninterrupted immobilization, decalcification of the sclerosis will be observed, signs of union will follow, and ultimately solid bony union will take place. When fresh fractures are adequately immobilized, the development of avascular necrosis in the

[1] *J. Bone & Joint Surg.*, October, 1954.

proximal fragment is not regarded as a contraindication to continued non-operative treatment. Stewart has found that in the majority of cases, the fracture will unite and the proximal fragment will be revascularized; the wrist must be protected until revascularization is complete. As against this he considers that rarely will normal function of the wrist be obtained as a sequel to excision. Nor will bone grafting or drilling, except in an occasional case, offer any better prospect of union or reduce the average period of disability. However, in the occasional fracture with excessive displacement of the proximal third, early excision of the proximal fragment is advisable, unless accurate reduction can be obtained by manipulation.

Stewart selected for immobilization a position of maximum relaxation of the carpus, a "grasping pose". The wrist was placed in extension of approximately 30° with mid-ulnar and radial deviation. The first metacarpal was abducted, while the metacarpo-phalangeal and inter-phalangeal joints of the thumb were flexed toward the palm. A circular plaster cast, skin-tight except for one layer of stockinette, was applied from one inch below the elbow to the metacarpo-phalangeal joints and the base of the thumbnail on the dorsal aspect and to the proximal crease on the palmar side. The hand could thus be passed through the sleeve of the average shirt or coat. Movement of the interphalangeal joint of the thumb was allowed, provided the plaster did not weaken and permit movement of the first metacarpo-phalangeal joint, the point being that since the middle fibres of the abductor of the thumb are attached to the tubercle of the navicular, movement of the first metacarpo-phalangeal joint would move the fracture. The thumb was relaxed, and the metacarpo-phalangeal joints of the fingers were completely free. The patients were able to carry on an active programme of work or play, and they were encouraged to participate in rope-climbing, tumbling, chinning exercises, bag punching and even baseball. The policy was to change the cast and to reexamine the navicular radiographically at the end of every four to six weeks. When the plaster was removed, the patient was instructed not to move the thumb or wrist.

Stewart believes that immobilization may be prolonged for a year or more if daily exercise and activity of the fingers are systematically practised; and patience may certainly be a requirement of both surgeon and patient. However, the three golden rules remain paramount: diagnose early, reduce accurately, immobilize adequately.

DERMATOLOGICAL PROBLEMS ASSOCIATED WITH THE USE OF DIESEL POWER.

DERMATOLOGICAL PROBLEMS associated with the use of Diesel power have been brought to notice recently by W. B. Guy,[1] whose interest in them was aroused by their increasing incidence as a result of the widespread adoption of the Diesel type of locomotive in the railway industry. Guy states that the dermatitides appearing since Dieselization [*sic*] are indeed perplexing and present many peculiar angles and particular features. He divides them into three groups: (i) those due to procedures used in cleaning and maintaining engine parts, (ii) those due to fuel oil itself, (iii) those due to chromates used as anticorrosion agents in Diesel radiators. In general, it appears, the problems associated with cleaning Diesel engines are the same as those associated with the servicing of steam engines, and they present no particular difficulties; but there are special circumstances which can alter the picture. The air boxes surrounding the Diesel cylinders are full of sand, grit and soot, and in the cleaning process the entire cylinder head is sometimes sprayed with Diesel fuel oil. The men engaged in this process are in contact with oil from the spray mist and a special hazard results. Diesel fuel oil has solvent properties, so that it can defat the skin surface, thus acting as a primary irritant. Additives intended to increase the power of the fuel also increase these irritant tendencies. Some men have been found to develop a true contact type of skin sensitivity to Diesel fuel oil, and this has proved to be totally disabling so far as working in railway workshops is concerned. It seems that almost everything in the workshop becomes contaminated with Diesel fuel, and avoidance of contact is practically impossible. The resultant situation can be serious for both employer and employee. The third group of problems results from the use of chrome salts as antirust agents in Diesel cooling systems; for example, sodium bichromate is used in a strength of 0·08% in Diesel radiator fluid. The hazard of contact is experienced by workers engaged in filling and draining the radiator systems. However, other workers also have acquired sensitivity from casual and incidental contact, although they have not been engaged in filling and draining radiators. Guy states that the unusual feature of chrome dermatitis is its chronicity and recalcitrance to usual methods of treatment. This may be due to the setting up of a neurodermatitis. Fortunately, the rash usually responds to treatment with cortisone and corticotropin; hydrocortisone ointment in 2·5% strength also effectively controls the process. Another possible line of treatment is with dimercaprol (BAL) ointment. H. N. Cole, junior (quoted by Guy), has reported good results from the use of 3% dimercaprol ointment in the treatment of chronic chrome dermatitis. His patients were six lithographers and one man in the chrome-plating industry.

[1] *Arch. Dermat. & Syph.*, September, 1954.

THE BROMPTON HOSPITAL.

IN a well-written and competently constructed account of one of the first special hospitals to be established in the United Kingdom, Dr. Maurice Davidson and Mr. F. G. Rouvray make it clear[1] that in 1841 their hospital came into existence through the humanitarian impulses, vision and determination of a few adventurous spirits; they saw the need plainly, knew exactly what they wanted, and then used their natural gifts to translate ideals of perfection into effective action. But there is far more than the story of a great adventure in the history of the Brompton Hospital, London.

The actual founder of the Brompton Hospital for Diseases of the Chest, and the presiding genius over its destinies for over forty years, was Sir Philip Rose, member of a firm of solicitors in London. Personal experiences had already convinced him that the spread of consumption was a growing menace to the community; that its prevention and cure were matters for expert study; and that consumptives were rigidly denied the right of medical care or treatment in all general hospitals throughout the country.

Fortunately, Philip Rose had the brains and ability to capture the hearts and enlist the help of the most influential people in the land. He wisely sought the advice and professional services of distinguished physicians who were unrivalled in their knowledge of diseases of the chest; and he helped to inculcate an enduring principle that nothing but the best will do for an institution with such ambitious schemes in mind. It is noteworthy that the first honorary physicians to be appointed to the staff had commenced their careers by attending Laennec's clinic at the Charité in order to gain experience in the new methods of physical diagnosis. In following the orderly and sustained progress of this highly specialized hospital and the modern Frimley Sanatorium associated with it, one cannot fail to observe the ready acceptance of all the latest trends in the medical and surgical management of chest conditions, and the gradual introduction of other special departments which scientific development has made essential to proper investigation, treatment or research.

There are several portraits giving emphasis to the fine character of the Brompton Hospital builders, while other illustrations are a testimony to the high standard of its buildings.

[1] "The Brompton Hospital: The Story of a Great Adventure", by Maurice Davidson, M.A., D.M. (Oxon.), F.R.C.P. (London), and F. G. Rouvray, O.B.E.; 1954. London: Lloyd-Luke (Medical Books), Limited. 10" × 7½", pp. 160, with 31 illustrations. Price: 21s.

Abstracts from Medical Literature.

OBSTETRICS AND GYNÆCOLOGY.

Psychological Aspects of Uterine Dysfunction.

W. A. CRAMOND (*Lancet*, December 18, 1954) describes an investigation of psychological factors in uterine dysfunction. He states that 50 patients with major uterine dysfunction were compared with a control group which was matched for age, height and social class. He describes a "dysfunction temperament" characterized by suppression or repression of feelings of tension. He states that the patients who exhibited this temperament tended to be reserved, even suspicious, and had difficulty in talking about themselves or their problems. It was noted also that they were more conventional than normal. The "dysfunction temperament" was found in 54% of the dysfunction subjects compared with 12% of the controls. The author states that this investigation confirms the fact that uterine dysfunction is of multiple ætiology, in which age, prolongation of the gestation period, the occipito-posterior presentation and personality all play a greater or less part in any one case. It is thought that psychiatric methods of prediction and prevention in the antenatal period would have no effect on the occurrence of uterine dysfunction.

The Emotional Component in Trichomonas Vaginitis.

S. F. MOORE AND J. W. SIMPSON (*Am. J. Obst. & Gynec.*, October, 1954) discuss the unsatisfactory results of local treatment of trichomonas vaginitis and suggest that the disease is emotionally conditioned and essentially psychosomatic in nature. They state that there is no certain knowledge of the cause and nature of the physiological changes in the vagina which favour the growth and multiplication of trichomonads. Such changes in vaginal physiology may be produced by emotional stress. This theory accepts the trichomonad as the specific infectious agent but holds that the organism is incapable of producing symptoms except when the vagina is conditioned by the effects of disturbed emotions. Associated symptoms such as nervousness, fatigue, menstrual irregularities and painful breasts are often present in the patient suffering from chronic trichomonas vaginitis. Frigidity and dyspareunia are associated psychosexual disorders in some of these patients. The authors consider that any stress situation seems capable of evoking this response if sustained sufficiently long, or if of great enough intensity. Their treatment of trichomonas vaginitis is concerned primarily with the emotional component but includes local therapy, rest and sedation. A full history is considered essential, and the patient is encouraged to talk freely and tell her own story. Physical examination is performed along routine gynæcological lines, and the diagnosis is confirmed by fresh drop examination of the discharge. As soon as the diagnosis is established, some form of local treatment is commenced, but this is minimal in order to avoid concentrating the patient's attention on her vaginal symptoms. The patient is reassured that she can be cured, and any fears of conditions such as venereal disease, cancer or offensive odour are allayed. Psychotherapeutic measures are usually simple and aim at providing emotional support and some degree of reeducation. The authors conclude that their results in the treatment of trichomonas vaginitis have improved immeasurably since their management of the condition as a psychosomatic symptom.

Vitamin B Treatment for Dysmenorrhœa.

A. P. HUDGINS (*Western J. Surg.*, December, 1954) gives the results of treatment of patients suffering from dysmenorrhœa with niacin, rutin and ascorbic acid in a series of 220 cases. Only those cases in which the patients had cramps severe enough to require bed rest, time loss or heavy sedation were included in the series. The basic dose was 100 milligrammes of niacin every morning and evening, and 100 milligrammes every two to three hours during the cramping period. The author states that each dose may be increased by 50 to 100 milligrammes or more to maintain flushing for maximum effect, as it was found that pain relief was more apparent with flushing, and the patients were warned accordingly. The effectiveness of niacin was improved by the addition of rutin (60 milligrammes) with ascorbic acid (300 milligrammes) daily. This effect was thought to be due to the improved capillary permeability, which made more effective the vasodilating effect of the niacin. In most cases niacin was not effective unless it had been taken seven to ten days before the onset of the menstrual flow. The author states that the effectiveness is noted for several months after therapy is discontinued, which seems to indicate that it is nutritional in origin. Approximately 90% of the patients studied were relieved of cramps.

Sarcoma Botryoides.

R. N. CREADICK (*Am. J. Obst. & Gynec.*, August, 1954) reviews the historical background and discusses theories concerning the origin and development of the rare and fatal tumour, *sarcoma botryoides*. He reports five cases observed at Duke Hospital in the last twenty-five years. He considers the term *sarcoma botryoides* a misnomer and prefers McFarland's suggestion of "dysontogenetic" tumour. He states that there is frequently a great diversity of tissue in these tumours, and many theories have been advanced to explain their origin. The occurrence of this neoplasm in very young patients and occasionally in postmenopausal women may favour the theory of "embryonic vestiges" of Cohnheim. Bone, fat, cartilage and muscle have been reported in these tumours, and the presence of adult nerve tissue has been noted once in the literature. In one instance a *sarcoma botryoides* developed during the intrauterine life of a fœtus. The highest reported age of a patient with such a tumour was sixty-nine years. *Sarcoma botryoides* usually presents in the vagina or at the vulva, and commonly arises from the anterior lip of the cervix or the upper part of the vagina. Suppuration and necrosis of the neoplasm are said to be frequent. The vagina may be distended by growth, and retention of urine may result. Histologically the tumours show spindle cells, round cells and interlacing fibrils of thin connective tissue cells. A grey myxomatous fluid is usually present. The average survival rate of patients with *sarcoma botryoides* is said to be from eighteen months to three years. In none of the five cases reported did the patient survive longer than two years. The condition is usually unsuspected, and early diagnosis is missed. The author makes a plea for earlier diagnosis despite the rarity of the tumour and stresses the importance of vaginal smear examination for cancer cells. He states that local spread and recurrence of *sarcoma botryoides* is common, but distant metastases are rare. Local excision of the tumour has been discarded as a method of treatment, and irradiation has been unsuccessful. A few patients may be amenable to radical surgery in hope of a cure.

Intravenous "Pitocin" Therapy for Toxæmias of Pregnancy.

J. C. PARKER AND L. W. ROBERTS (*Am. J. Obst. & Gynec.*, August, 1954) report 35 cases of successful induction of labour in toxæmia of pregnancy by the intravenous use of "Pitocin". They consider that the use of "Pitocin" or any oxytocic agent prior to the birth of the baby is a hazardous procedure and should be undertaken only by well-trained personnel. The duration of a given toxæmia of pregnancy is thought to be of more significance in relation to permanent hypertension than the severity of the toxæmia. Accordingly they believe that pregnancy should be terminated if a patient suffering from toxæmia fails to show improvement or worsens after a reasonable period of therapy. In severe cases of preeclamptic toxæmia in which convulsions seem imminent, temporization by induction is not permitted, and Cæsarean section affords the quickest and best way of terminating pregnancy. Prior to the induction of labour by intravenous administration of "Pitocin", the presentation and position of the fœtus, any question of cephalo-pelvic disproportion and the state of the cervix should be assessed. Contrary to the experience of some other workers, the authors found that intravenous administration of "Pitocin" was successful in inducing labour in their cases of toxæmia of pregnancy even when the cervix was "unripe". They employ a 1 : 2000 concentration of "Pitocin" in 5% dextrose in distilled water, generally using 0·25 millilitre in 500 millilitres respectively. This is allowed to run at a rate of 30 to 40 drops per minute. Since the majority of the patients receiving "Pitocin" drip therapy have "unripe" cervices

that are not amenable to the usual methods of inducing labour, it may be necessary to administer the infusion over a period of several days before labour begins. In the authors' series the periods of gestation varied from thirty-two weeks to several weeks past term. There were no maternal deaths in the series and no untoward effects noted in any mother as a result of the intravenous use of "Pitocin". There was one stillbirth in the series under review. The authors consider that, in experienced hands, intravenous "Pitocin" therapy is a valuable adjunct in the treatment of toxæmia of pregnancy. Moreover, this method of treatment should reduce the number of Cæsarean sections performed for toxæmia of pregnancy and thus reduce the number of obstetrical cripples.

Experiences with Vaginal Hysterectomy.

W. Z. BRADFORD, W. B. BRADFORD, J. H. E. WOLTZ AND C. W. BROWN (*Am. J. Obst. & Gynec.*, August, 1954) report experiences based on a study of 184 consecutive operations of vaginal hysterectomy. They stress the importance of careful appraisal and selection of patients for this operation. The operation is usually employed when there are clear-cut indications for hysterectomy associated with some degree of genital prolapse. The authors have enlarged the sphere of usefulness of this operation in recent years with a corresponding decline in the use of the Manchester operation. Of the patients in their series 38% were over fifty years of age, and vaginal hysterectomy combined with repair was performed on 174 of the 184 patients. The chief pathological lesson of the series consisted of some form of genital prolapse associated with lesions such as diseased cervix, intraepithelial cancer of the cervix, uterine fibroid tumours, adenomyosis and adenocarcinoma of the fundus. Of the patients reviewed 20% had undergone previous gynæcological operations. Vaginal hysterectomy was performed on account of symptoms and pathological conditions which had not been relieved by previous surgery. The authors consider that inadequate and ill-chosen surgery on the one hand and unnecessary hysterectomy on the other hand have to be assessed. A history of previous pelvic surgery should give a warning of possible technical difficulty but should not, in itself, be considered a contraindication to vaginal hysterectomy. The completion of vaginal hysterectomy was technically impossible in one case because the patient had had a ventral fixation. The cervix was amputated and repair effected as in the Manchester operation, and the uterus was then removed by the abdominal route. The operative technique employed by the authors is briefly described. They consider that a diversity of technique has revealed no striking variation in end-result provided fascial reconstruction was accomplished. Adequate closure of the cul-de-sac with or without the presence of an enterocele is considered important in operative technique. There were no deaths in the series reviewed. Delayed post-operative hæmorrhage occurred in five cases between the tenth and twenty-second days after operation. A broad ligament hæmatoma occurred in one case, and pelvic infection complicated eight cases. Patients were usually allowed out of bed from the second to the fifth post-operative day, and the indwelling catheter was removed on the fifth day.

The Trend of Changes in Causes of Perinatal Mortality.

E. L. POTTER (*J.A.M.A.*, December 18, 1954) states that combined mortality for fœtuses and for infants less than four weeks of age in the United States has fallen from 79·1% per 1000 live births in 1922 to 43·4% per 1000 in 1950. The incidence of premature delivery does not seem to have changed appreciably in the last twenty years, but survival rates for premature infants have considerably improved. Causes of perinatal mortality are malformations, erythroblastosis, intrauterine anoxia, trauma, prematurity, infections, non-infectious pulmonary disturbances and a small group of miscellaneous conditions. All causes of perinatal deaths have decreased except malformations and erythroblastosis; syphilis has largely disappeared. With the exception of syphilis, trauma and anoxia associated with labour and delivery have shown more decrease in special obstetric hospitals than any other causes. These are the most fertile fields for immediate further national reduction in perinatal mortality rates.

Management of Labour and Prevention of Perinatal Mortality.

G. E. JUDD (*J.A.M.A.*, December 18, 1954) states that during labour a number of general measures, including early examination, proper planning, good nursing care and general supportive measures, will promote fœtal salvage. Maternal factors such as age, gravidity, previous history, nutrition and prenatal care influence fœtal loss. Factors of fœtal risk vary with different presentations and types of delivery; evaluation of fœtal risk should help determine the type of delivery to be employed when a choice is possible. Management of premature labour differs from management of term labour in medication, type of anæsthesia and reduction of birth trauma. The cord blood should be given to the baby by stripping, delay in clamping or placental transfusion. Resuscitation of the newborn infant should be gentle, swift and efficient. Mechanical removal of extraneous material from the air passageway is vital. Warmth and early oxygenation are very important; prompt administration of vitamin *K* and antibiotics is important when indicated. In endeavours to reduce perinatal mortality sight must not be lost of the primary responsibility, the welfare of the mother.

Blood-Flow in the Uterine Wall in Late Pregnancy.

N. MORRIS, S. B. OSBORN AND H. P. WRIGHT (*Lancet*, February 12, 1955) describe a method for the measurement of effective blood-flow in the uterine wall during pregnancy; the method involves the clearance-rate technique. Observations of the effective flow between the thirtieth week of gestation and term were made on 20 normotensive women, on 10 with normal twin pregnancies and on 18 with pre-eclampsia (mild in 10 cases, severe in eight). The authors state that in twin gestation the clearance rate was somewhat decreased compared with that in normal single pregnancy. The effective flow was about half the normal in mild cases of pre-eclampsia and only a quarter of the normal in severe cases. Measurements suggest that therapy with hypotensive drugs in cases of pre-eclampsia increases the effective blood-flow in the uterine wall. The authors state that it is obvious that any measure which increases uterine, and hence placental, nutrition must be advantageous to the development of the fœtus. The ultimate success of such treatment, however, depends on the capacity of the placenta; if this organ is already grossly infarcted or underdeveloped it may still fail to sustain fœtal life, even though the blood-flow in the uterine wall is restored to normal.

MEDICINE.

Glucose Threshold in Kimmelstiel-Wilson's Syndrome.

J. L. GRANT (*New England J. Med.*, August 19, 1954) reports the blood sugar and urinary sugar levels in 11 patients with a Kimmelsteil-Wilson syndrome and compares them with the same findings in a series of patients with uncomplicated diabetes. It is shown that the average renal threshold for glucose is raised in the Kimmelsteil-Wilson syndrome. The author states that the apparent lowering in urinary sugar content in patients being treated for diabetes may be due to the result of intercapillary glomerulosclerosis. The explanation of the raised threshold for glucose lies in the pathological changes in the glomeruli which reduce filtration and consequently the total load of glucose presented to the tubules.

The Gastro-Œsophageal Vestibule.

FRANK J. INGELFINGER, PHILIP KRAMER AND GUILLERMO C. SANCHEZ (*Am. J. M. Sc.*, October, 1954) have studied the motor functions of the œsophagus by pressure measurement through thin tubes and by radiological and pharmacological means. They find that the œsophagus may be divided into three sections, the mid-œsophagus, the ampulla and the vestibule. The characteristic pressure waves for these regions have been shown to differ, and their modification by cholinergic and anti-cholinergic drugs suggests that the body of the œsophagus and the vestibule react inversely. It is suggested that cardiospasm is simply achalasia of the vestibule or merely failure to relax when the bolus reaches this area. It is also suggested that motor abnormality of the vestibule may underlie some types of gastro-œsophageal reflux.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A meeting of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on February 14, 15 and 16, 1955, Sir Archibald Collins, the President, in the chair.

Congratulations.

At the outset of the meeting Dr. H. C. Colville, on behalf of the members of the Federal Council, congratulated Sir Archibald Collins on the recent honour which had been conferred on him by Her Majesty the Queen. He spoke of the distinguished services which Sir Archibald Collins had rendered to the medical profession over many years, and said that no honour had brought more general satisfaction to the members of the profession. Sir Archibald Collins thanked the members.

Minutes.

The minutes of the Federal Council meeting of August 30 and 31 and September 1, 1954, and of October 28, 1954, which had been circulated amongst members, were taken as read and signed as correct.

Representatives.

The following representatives of the Branches were present:

New South Wales: Sir Archibald Collins, D.S.O., M.C., Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. J. Murray, O.B.E.

Queensland: Dr. A. E. Lee, Dr. H. W. Horn.

South Australia: Dr. L. R. Mallen, Dr. C. O. F. Rieger.

Tasmania: Dr. J. B. G. Muir, Dr. L. N. Gollan.

Victoria: Dr. H. C. Colville, Dr. Charles Byrne, Dr. Robert Southby.

Western Australia: Dr. D. E. Copping, Dr. C. W. Anderson.

Honours.

The General Secretary referred to honours which had recently been conferred by Her Majesty the Queen on members of the medical profession in Australia. The knighthood of Sir Archibald Collins had already been mentioned. Dr. William Edward Lodewyk Hamilton Crowther, who had been a member of the Federal Council from March 16, 1936, to December 31, 1940, had been created a Commander of the Most Excellent Order of the British Empire, and Dr. Moya Kathleen Bailey, of Canberra, had been made a Member of the same Order. Letters of congratulation had been sent to Dr. Crowther and Dr. Bailey.

Appointment of Office-Bearers.

The General Secretary reported that only one nomination had been received for the position of President, that of Sir Archibald Collins. Sir Archibald Collins thanked the members of the Federal Council for their continued confidence in him, and for his election for a further period.

Only one nomination had been received for the position of Vice-President, that of Dr. H. C. Colville. The President declared Dr. Colville elected.

Only one nomination had been received for the position of Honorary Treasurer, that of Dr. W. F. Simmons. The President declared Dr. Simmons elected.

Annual Report.

The General Secretary presented the annual report of the Federal Council for the twelve months ended December 31, 1954. The report was received, and the General Secretary was congratulated on the way in which he had condensed the proceedings of the Federal Council and produced a readable document.

Finance.

The financial statement of the Federal Council as at December 31, 1954, was presented by Dr. W. F. Simmons, the Honorary Treasurer, and adopted. Dr. Simmons pointed out that the finances of the Federal Council were in a healthy condition. He set out an estimated amount of the expenses which in his opinion were likely to be incurred during the year 1955. Provision was made for three meetings of the Federal Council during the year. The sum of £1250 was estimated to be necessary to meet the expenses of sending a delegate to the meeting of th World Medical Association and the subscription of the Federal Council to the association. A further sum of £800 would probably be needed to send a delegate to the British Commonwealth Medical Conference, to be held later on in the year at Toronto. Dr. Simmons also referred to the financial statement of the Australasian Medical Congress (British Medical Association), and pointed out that this fund was in a satisfactory condition. It was at present being operated on in connexion with the forthcoming congress to be held at Sydney in August, 1955. The financial statement was adopted.

Dr. Simmons presented a statement setting out the per-capita payments of the Branches for the year 1955, and this was adopted. At a later stage of the meeting Dr. L. R. Mallen gave notice of motion that at the next meeting of the Federal Council he would move that By-Law 15 (iii) should be amended by the deletion of the words "twenty-one shillings" and the substitution in lieu thereof of the words "thirty shillings". He explained that the activities of the Federal Council were increasing. The number of members was increasing, and an increase in members always meant an increase in the amount of work that had to be done, and this would have to be paid for. He added that because the per-capita payment limit was raised from 21s. to 30s. *per annum*, this did not mean that the amount of 30s. would be used.

Dr. Simmons presented a statement showing the position of the Organization Fund for the period ended December 31, 1954. The amount standing to the credit of the fund was £1923.

Dr. Simmons presented a statement showing the position of the Federal Independence Fund as at December 31, 1954. The amount standing to the credit of the fund was £22,883 11s. 3d. He explained that no further applications for the refund of unexpended portions of contributions had been received since the date of the last meeting. The statement was received.

Dr. Simmons pointed out that the Entertainment Fund of the Federal Council still stood at £251.

During the discussion on matters connected with the World Medical Association later on in the meeting, reference was made to the fact that delegates representing the Federal Council overseas or at official conferences in Australia were paid no practice allowance. A practice allowance was paid to members of the Federal Council when they attended meetings of the Council, and it was thought that a similar provision should be made for delegates representing the Federal Council overseas or at official conferences in Australia. It was resolved that the allowance for this purpose should be four guineas a day during the period of their absence from their practices.

Mr. G. D. Alexander was appointed as auditor of the Federal Council for the ensuing twelve months.

Henry Simpson Newland Prize in Surgery.

Dr. W. F. Simmons, the Honorary Treasurer, presented a statement of the present position of the Henry Simpson Newland Prize Fund in Surgery. The amount standing to the credit of the fund was £1099.

The President produced a bronze medal which had been prepared for presentation to the winner of the prize. On one side was depicted the head of Sir Henry Newland, and on the other there was a statement showing the name of the prize. The medal had been prepared through the good offices of Dr. H. C. Colville. Dr. Colville said that he was not really satisfied with the end result, and that he hoped to have some improvements effected. The President expressed the appreciation of the Federal Council for all the trouble to which Dr. Colville had gone.

Medical Officers' Relief Fund (Federal).

On behalf of the trustees of the Medical Officers' Relief Fund (Federal), Dr. W. F. Simmons presented a report for the year ended December 31, 1954. The fund at present stood at £7513 19s. 7d. During the year the sum of £310 had been paid to four beneficiaries. One loan amounting to £700 (exclusive of interest owing) was in existence at December 31, 1954; this was the same as at December 31, 1953. The report was adopted.

FEDERAL MEDICAL WAR RELIEF FUND.

On behalf of the trustees of the Federal Medical War Relief Fund, Dr. W. F. Simmons presented a report for the year ended December 31, 1954. The total assets at December 31, 1954, had amounted to £18,921 14s. 7d. Assets in the nature of cash in the bank and treasury bonds had decreased during the year by £505 19s. 7d. The amounts paid to fourteen beneficiaries during the twelve months amounted to £1350. The report was adopted.

INQUIRIES FROM OVERSEAS ABOUT MEDICAL PRACTICE IN AUSTRALIA.

The General Secretary reported that he had as usual received several inquiries from medical practitioners overseas in regard to conditions of practice in Australia. He had sent a suitable reply in every instance.

THE NORTHERN TERRITORY MEDICAL SERVICE.

The General Secretary reported that he had received a request from the Victorian Branch, asking for information on the cost of the Northern Territory Medical Service. He had inquired from the Minister for Health, and had been informed that the total cost for the year was £533,840.

REPRESENTATIVE TO THE SEMINAR ON HEALTH EDUCATION.

The General Secretary reported that he had received from the South Australian Branch a request that Dr. C. C. Jungfer should be appointed representative of the Federal Council at the seminar on health education, to be held at Canberra on January 12 to 21, 1955. Dr. Jungfer had been appointed.

ASIAN AND PACIFIC TUBERCULOSIS CONFERENCE.

The General Secretary reported that he had received a memorandum from Dr. Cotter Harvey, the Acting President of the National Association for the Prevention of Tuberculosis in Australia, in regard to the Asian and Pacific Tuberculosis Conference, which was to be held at Sydney in the week commencing August 15, 1955, immediately before the ninth session of the Australasian Medical Congress (British Medical Association). The conference was being organized by the National Association for the Prevention of Tuberculosis in Australia, and it had the support of the Commonwealth Government. The Minister for External Affairs was sponsoring a delegation from the following "Colombo Plan" countries: India, Pakistan, Ceylon, Burma, Singapore, Malaya, Sarawak and North Borneo, Thailand, Indo-China, Indonesia and the Philippines. Invitations to attend had also been sent to the National Association for the Prevention of Tuberculosis, to the National Tuberculosis Association of the United States of America, and to the Canadian Tuberculosis Association. It was anticipated that many delegates from all the Australian States and from New Zealand would attend. A complete scientific programme was being drawn up and would shortly be available.

AUSTRALIAN DIETETIC COUNCIL.

The General Secretary said that a request had been received from the Australian Dietetic Council for the nomination of a representative to give advice on nutritional matters. The appointment of a representative was left in the hands of the office of the Federal Council.

ALL-INDIA MEDICAL ASSOCIATION.

A request that messages of goodwill should be sent to the first All-India Medical Conference, Lucknow, which was to be held on December 26, 1954, had been received. However, the letter had not arrived until January 6, 1955.

SYNDICAT NATIONAL DES GYNÉCOLOGUES ET OBSTÉTRICIENS FRANÇAIS.

The General Secretary said that he had received an inquiry from the *Syndicat national des gynécologues et obstétriciens français* about the existence of a professional organization of gynæcologists and obstetricians in Australia. A reply had been sent referring the organization to the Regional Council of the Royal College of Obstetricians and Gynæcologists in Australia.

MEDICAL PRACTICE AT BURNIE, TASMANIA.

A further communication had been received from the Associated Pulp and Paper Makers' Council in regard to medical services at Burnie, Tasmania. Advice was sought in regard to medical services at Burnie, and it was suggested that there were insufficient private practitioners in that town. The General Secretary said that the matter had been referred to the Council of the Tasmanian Branch, and that a reply had been received that it was probably true that there was room for another practitioner in Burnie. It was pointed out, however, that private practitioners in that town laboured under the disability that there were no intermediate or private hospital beds available in which practitioners could treat their patients, and that this was a deterrent to the establishment of private practice in that area. The Associated Pulp and Paper Manufacturers' Council had been so informed.

AUSTRALASIAN MEDICAL CONGRESS (BRITISH MEDICAL ASSOCIATION).

Reference was made to the ninth session of the Australasian Medical Congress (British Medical Association), which was to be held at Sydney on August 20 to 27, 1955.

It was noted that Dr. Terence C. Butler had been appointed one of the vice-presidents on the nomination of the Tasmanian Branch. It was further noted that the invitation of the Federal Council under Rule IX had been accepted by Sir John Newman-Morris.

The General Secretary reported that Dr. Louis Bauer, Secretary-General of the World Medical Association and a Past President of the American Medical Association, had accepted an invitation to deliver the Henry Simpson Newland Oration at the time of Congress.

The General Secretary reported that the Parent Body had appointed Dr. A. Talbot Rogers, a member of the Council and Chairman of the General Medical Services Committee, to represent the Parent Body at the ninth session of Congress. The following were appointed honorary members of Congress on the nomination of the Executive: The Most Reverend the Archbishop of Sydney, Dr. H. W. K. Mowll; His Eminence Cardinal Gilroy; the Reverend Dr. Cumming Thom; the Reverend J. H. Sorrell, M.M., E.D.; Rabbi Dr. I. Porush; the Right Honourable Sir Earle Page, G.C.M.G., C.H., M.P.; the Honourable J. J. Cahill, M.L.A.; the Honourable M. O'Sullivan, M.L.A.; the Honourable W. H. Lamb, M.L.A.; the Honourable W. E. Dickson, M.L.C.; the Right Honourable the Lord Mayor of Sydney, Alderman P. D. Hills, M.L.A.; the Honourable K. W. Street; Sir Charles Bickerton Blackburn, Kt., O.B.E.; Professor S. H. Roberts; Mr. H. W. Maze; Dr. Robert Scot Skirving; Sir Stanford Cade; Dr. C. E. Eddy; Dr. Mervyn Archdall.

The General Secretary said that he had had some correspondence with Dr. H. J. Ham regarding the proposed formation of an Australian Cancer Society. He pointed out that the National Association for the Prevention of Tuberculosis in Australia had been formed after the adoption of a resolution by the seventh session of Congress at Perth in 1948. The subject for discussion at the first plenary session of the Congress in August was to be cancer. The General Secretary thought it possible that a resolution might be adopted at this session, and that as a result an Australian Cancer Society might be formed.

The General Secretary reported that the Governor-General, Sir William Slim, had accepted an invitation to become Patron of the ninth session.

It was resolved that the President of the Federal Council should be granted executive powers to deal with any urgent matters in connexion with the ninth session of the Congress arising between the present meeting of the Federal Council and the holding of the session.

AUSTRALASIAN MEDICAL PUBLISHING COMPANY, LIMITED.

The General Secretary reported that he had received a letter from the directors of the Australasian Medical Publishing Company, Limited, stating that there would be no alteration in the present per-capita payment of £1 for the supply of THE MEDICAL JOURNAL OF AUSTRALIA to members. Ten shillings of this amount was for the supply of the journal, and ten shillings would be repaid to the Branches in the form of debentures.

The General Secretary reported that steps were being taken to complete the publication of the 1955 list of members of the British Medical Association in Australia.

MEDICAL PLANNING.

National Health Service.

Pensioner Medical Service.

It will be remembered that at the meeting of the Federal Council held at Canberra on October 28, 1954 (see THE MEDICAL JOURNAL OF AUSTRALIA, November 27, 1954), the

Federal Council agreed to the formation of a joint committee of the Federal Government, representatives of the British Medical Association and the insurance organizations to devise a scheme whereby the maximum number of pensioners would be handled by medical benefits insurance instead of by the present system of concessional fees. The members of the Federal Council appointed to that subcommittee were Sir Archibald Collins, Dr. H. C. Colville and the General Secretary, Dr. J. G. Hunter. The Federal Council had before it the interim report of this committee, to which full consideration was given.

The scope of the Pensioner Medical Service was discussed, and it was decided that the Minister for Health should be informed that Sir Archibald Collins, Dr. H. R. R. Grieve, Dr. W. F. Simmons and the General Secretary had been requested by the Federal Council to confer with him in respect of the scope of the Pensioner Medical Service. It was also resolved that a report of that conference with the Minister for Health should be referred to the Branches for consideration.

The General Secretary referred to a communication from the Minister for Health, advising him of the altered rates of payment for the Pensioner Medical Service—namely, 10s. for each surgery consultation and 12s. for each domiciliary visit as from November 1, 1954. The General Secretary reported that he had had correspondence with the Director-General of Social Services, the Chairman of the Repatriation Commission and the Director-General of Health regarding the numbers of pensioners and dependants prior to the 1954 amendment of the *Social Services Consolidation Act*. The number was 584,436.

A communication was received from the New South Wales Branch, in which it was submitted that in the more sparsely populated areas where a practitioner might be sick or absent, the nearest practitioner treating a patient should be paid mileage fees. It was pointed out in discussion that if a practitioner was sick or absent, he could not be described as the nearest practitioner, and that therefore, if another practitioner more distant from the patient was called, that practitioner was in fact the nearest available practitioner. The Federal Council resolved to make a recommendation to the Minister for Health in terms of the New South Wales Branch resolution. The New South Wales Branch also wrote pointing out that some practitioners were at a disadvantage. They might be quite close to a patient, but be separated from him by a river which had to be crossed by ferry. In these circumstances the practitioner had to expend considerable time, which was the same as if he had to travel a long distance. The Federal Council resolved that the Commonwealth Government should be asked to give consideration to the payment of a special fee where the medical practitioner found it necessary to cross a river by ferry for the purpose of attending a pensioner.

General Pharmaceutical Benefits.

Further reference was made to the inadequacy of drugs for the "doctor's bag". Consideration of this matter had been deferred. At the Federal Council meeting in August, 1954, it was resolved that no further action should be taken.

The General Secretary reported that he had written to the Director-General of Health in the matter of suggestions for lessening the clerical work of a doctor in the endorsement of prescriptions; no reply had so far been received. It was resolved that the matter should be left in the hands of the General Secretary.

The General Secretary reported that he had received from the New South Wales Branch a letter to the effect that the annual meeting of delegates of Local Associations at its conference with the Council of the Branch had adopted a resolution to the effect that the Pharmaceutical Advisory Committee should be consulted by the Department of Health before any changes in the volume or method of prescribing of drugs under the national scheme were instituted. This matter had been referred to the Branches, and they had all supported the New South Wales view. The Federal Council adopted a resolution on the lines of the submission by the New South Wales Branch.

The General Secretary reported that he had received from the Director-General of Health advice that in regard to Amendment Number 5 to "Notes on the Pharmaceutical Benefits Regulations", 1954-1955 edition, arrangements were being made to reintroduce official prescription forms, and that it was anticipated that supplies would become available during January. A letter was received from the Victorian Branch, protesting against the reintroduction of these forms. It was resolved that the Federal Council should draw the attention of the Minister for Health to the fact that the printing of government prescription forms for pharmaceutical benefits was contrary to the policy of the Association. This had been one of the grounds for objection to the scheme of the Chifley Government. The Federal Council gave no credence to reports that practitioners had asked for the forms, and it decided to protest emphatically against the decision to reissue them.

A communication was received from the Director-General of Health, advising that the request that a dispensing fee should be paid to approved medical practitioners in regard to the provision of injectables and tablets had not been approved. The New South Wales Branch had requested that the matter should be taken up again with the Director-General of Health. Dr. W. F. Simmons pointed out that in the circumstances mentioned the medical practitioner ran the same risk, under law, as a registered pharmacist. Further, he supplied a public benefit, and Dr. Simmons expressed the opinion that this should be considered. It was resolved that a further request should be made to the Director-General of Health to reallow to approved medical practitioners the dispensing fee applicable to the supply of general pharmaceutical benefits.

At the August, 1954, meeting of the Federal Council, consideration was given to a request from the New South Wales Branch that it would be in the interest of all parties concerned if practitioners were made aware of the cost of drugs ordered by them. The Federal Council on that occasion resolved that a request should be made to the Minister for Health to provide medical practitioners with a schedule of the approximate prices of drugs supplied under the National Health (Pharmaceutical Benefits) Regulations. The General Secretary reported that the Director-General of Health had advised him that he would be glad to accede to the request to include in the "Notes for Medical Practitioners" approximate prices of drugs supplied under the Pharmaceutical Benefits Regulations.

Reference was made to the dosage and use of antibiotics, which had been referred to at the August, 1954, meeting of the Federal Council. It was resolved that no action should be taken until the new work sheet, which was being prepared by the Antibiotics Subcommittee of the National Health and Medical Research Council, was available. It was explained that this work sheet was in the press and would shortly be published in THE MEDICAL JOURNAL OF AUSTRALIA.

Medical Benefits.

A request was received from the New South Wales Branch calling attention to the large number of anomalies existing in the present schedule of benefits under the *National Health Act*. It was stated that experience gained since the inception of the scheme showed that these anomalies were increasing. Under the Act as it now stood, where a specific procedure was not listed in the schedules, payment was made on a visit basis, and in many cases the amount of the benefit so paid would remain so until the schedule was altered. As the success of the scheme depended largely on the goodwill of the public, it was thought to be only right that these anomalies should be abolished, and accordingly the New South Wales Branch recommended the Federal Council to press for an early revision of the schedule. The matter had been referred to the Branches, who had agreed with the suggestion made by the New South Wales Branch. The Federal Council therefore resolved that the Minister for Health should be requested to exclude the schedule of benefits from the *National Health Act*, and that he be further requested to appoint a Statutory Schedule of Benefits Committee, which should have the function of periodically reviewing the schedule of benefits.

A communication was received from the Ophthalmological Society of Australia (British Medical Association), forwarding the copy of a letter sent by the Minister for Health to a Member of Parliament, and asking for advice in regard to the present position. This was that the medical benefit did not include an attendance on an ophthalmic surgeon at which was made an examination of a patient's sight for the purpose of correcting errors of refraction by the prescription of spectacle lenses. The General Secretary pointed out that the prescription of lenses for a patient was often only incidental to a consultation in regard to the patient's vision and the condition of his eyes generally. He pointed out also that the anomaly would be rectified by the addition of the word "solely", so that an attendance would be excluded at which an examination of a patient's sight was made solely for the purpose of correcting errors of refraction.

A request was received from the Oto-Rhino-Laryngological Society of New South Wales, that the operation known as the Finzi-Harmer operation and its modifications,

namely, the fenestration of the laryngeal cartilages and the insertion of radium or radon applicators, should be added to the schedule of benefits.

Further reference was made to the definition of a specialist, which had been asked for by the Minister for Health in order that the payment of medical benefits under the Act might be facilitated. This matter was discussed at previous meetings of the Federal Council. An account of the discussion at the August meeting will be found in the issue of October 16, 1954, of THE MEDICAL JOURNAL OF AUSTRALIA at page 645. It will be remembered that the Federal Council adopted a definition in the following terms:

> That a specialist be defined as a registered medical practitioner who:
>
> 1. shall have served a period of at least one year as a Resident Medical Officer in an approved hospital;
> 2. declares himself to be exclusively engaged in the practice of a particular branch of medicine or surgery at a stated address;
> 3. shall have had three years' practical experience in that specialty;
> 4. possesses a degree or diploma of a recognized University, College or Faculty which is a certificate of higher qualification in such special branch of medicine or surgery and which degree or diploma is registrable under the relevant State or Federal Act;
>
> or,
>
> 5. while not possessing such a degree or diploma has been engaged in practice prior to the date of the institution of registration of specialists in a special branch of medicine or surgery for a period accepted as adequate by an appropriately constituted Board of Reference.
>
> Nothing in this definition will prevent a specialist from practising in other branches of medicine or surgery elsewhere.

The General Secretary pointed out that the Western Australian Branch had expressed strong disapproval of the definition, and had stated that it was not incumbent on the Association to advise the Government in the matter. The Royal Australasian College of Physicians had also disapproved of the second and terminal paragraphs of the definition, and had requested that its disapproval be conveyed to the Minister for Health, which had been done. The College wished to recommend that paragraph (c) of the suggested constitution of the Statutory Registering Tribunal should be amended so that the words "a representative of the faculty of medicine of each medical school of the Commonwealth" should replace the words "four deans of the medical schools of the Commonwealth". The regional Council in Australia of the Royal College of Obstetricians and Gynæcologists had also requested that it should be represented on any registering tribunal. In the discussion which took place, Dr. D. E. Copping expressed the view that the only proper way of defining a specialist was to require that he was recognized to be a specialist by his colleagues. Dr. H. W. Horn drew attention to the position of practitioners in the country who specialized in surgery. Many of these men enjoyed the confidence of their colleagues and were called upon to undertake many surgical procedures on their behalf. At the same time these men found it necessary, in order to gain a livelihood, to carry on a certain amount of general practice, and he insisted that they should not be prevented from doing so. Other members of the Federal Council stated that in certain areas of Australia it would be impossible to insist that a practitioner regarded as a specialist should confine his attention solely to the specialty in which he practised. It was pointed out in conclusion that the resolution had already been submitted to the Minister, and that it had not yet been approved. At the same time it was agreed that the subject should be discussed with the Minister.

A letter was received from the Western Australian Branch, requesting that consideration should be given to Section 21 of "Notes for Guidance of Registered Organizations", issued by the Commonwealth Department of Health. It was pointed out that the extraction of teeth by a medical practitioner was considered to be wrong in principle, for no rebate was payable to a medical practitioner in respect of a consultation at which it was necessary for teeth to be extracted. The Federal Council resolved to refer to the Commonwealth Department of Health the question of payment to medical practitioners of a benefit in respect of a consultation at which was diagnosed the need for teeth to be extracted.

Reference was made to M.B. Circular Number 14, "Level of Organization Benefits", issued by the Commonwealth Department of Health. In this document it was stated that a review of the operation of the Medical Benefits Scheme since its introduction on July 1, 1953, had revealed a tendency among some registered organizations to increase the general level of their benefits to an extent where they were greatly in excess of Commonwealth benefits. This practice, it was stated, had the inherent disadvantage that general increases in benefits could be absorbed by a higher medical fee. In the next paragraph it was stated that the increases in benefits suggested that the organizations should consider their position. It was stated that the increase in benefits suggested that the organizations considered their financial position warranted large returns to contributors. However, the rules relating to exclusions from benefits on account of waiting period, preexisting ailments and annual maximum benefits had been retained in many cases. These rules provided substantial ground for the criticism that exclusions from fund benefits, particularly the exclusion relating to preexisting ailments, detracted from the value and effectiveness of the scheme. In the third paragraph of the document it was stated that the Commonwealth policy was that where the stage was reached that benefit from the accumulated funds should be passed on to the contributors and it was not desirable or practicable to reduce the rates of contribution, the organization should relax its excluding rules rather than raise the general level of benefit. The adoption of this policy by registered organizations would eliminate one of the few remaining grounds for criticism of the Medical Benefit Scheme. Registered organizations that had surplus accumulated founds would be required therefore to examine their rules with a view to removing or relaxing restrictions on the payment of fund benefits before requesting approval for any general increase in the level of fund benefits. In the fourth paragraph it was stated that the policy mentioned would be applied to future proposals by organizations to increase fund benefits. It was not intended, however, to prevent an organization from increasing its benefit for a particular medical service where it could be demonstrated that the supplemented benefit for that service was inadequate by comparison with the general level of benefits. Nor was it intended to prevent an organization from establishing a new table providing higher benefits for higher rates of contributions. The New South Wales Branch wrote that the circular had been recently considered by the Branch Council, and that it had been decided to recommend to the Federal Council that a strong protest be made to the Government in regard to the policy of requiring organizations that had surplus funds to examine their rules with a view to removing or relaxing restrictions on the payment of fund benefits before requesting approval for any general increase in the level of fund benefits. In the discussion it was made clear that members of the Council thought that the matter was no business of the Federal Government, and that organizations should have the power to build up reserve funds. As a matter of fact it was pointed out that it was necessary that reserve funds should be available; otherwise the funds would be in serious danger of being totally expended in the occurrence of epidemics and so forth. Dr. D. E. Copping suggested that the matter was no business of the Federal Council. Dr. H. C. Colville agreed with this point of view, and remarked that very often the question of the payment of a benefit in the presence of a previous illness depended on the decision of some clerk who knew nothing whatever about the matter. The New South Wales Branch drew attention to what might be regarded as a slur on the medical profession in the first paragraph of the circular. On discussion it was resolved that no notice should be taken of the statement in question. One member expressed the view that to take notice of the statement would be small-minded and undignified.

Attention was drawn to Circular N.M. 14, which had to do with the payment of benefits for out-patient services in hospitals, but which had now been withdrawn.

Reference was made to a decision of the Federal Council at its August, 1954, meeting that the Minister for Health should be requested to give consideration to the subsidizing of medical benefits organizations in order that fund benefits might be paid to persons suffering from preexisting illnesses during the period of their exclusion from benefit. The General Secretary said that he had discussed the matter with the Minister. The Minister had stated that he had looked at it, but that he had not yet been able to assess the financial considerations involved. However, the matter was receiving his attention.

Medical Services Committees of Inquiry.

At the August, 1954, meeting of the Federal Council, discussion took place on the Medical Services Committees of Inquiry. The matter on that occasion was introduced at the instance of the Western Australian Branch by Dr. C. W. Anderson and consideration was deferred. Dr. Anderson now raised the matter again. The General Secretary pointed out that the scope of the service was not clearly understood, and that to tell members of the medical profession that the scope was that of the Common Form of Agreement, as indeed it was, did not convey anything to the minds of many practitioners who had never worked under a Common Form of Agreement. The present generation of medical practitioners was "a generation which knew not Joseph". Reference was here made to the request for a conference with the Minister for Health which has previously been mentioned, and it was pointed out that when the position with regard to the scope of the service was clarified, the work of these Committees of Inquiry might possibly be made easier.

Hospital Policy.

A letter was received from the Western Australian Branch, objecting to the sessional method of payment in respect of part-time visiting medical officers (anæsthetists) employed by the Western Australian Department of Health, but attached to the Thoracic Unit at the Royal Perth Hospital. The Western Australian Branch drew attention to an advertisement which had been submitted to them before being sent to THE MEDICAL JOURNAL OF AUSTRALIA. In this advertisement payment was set out on a sessional basis. The Branch had written to the Public Health Department to the effect that it was opposed to the principle of doctors being employed on a sessional basis, and recommended that the Department should endeavour to make such an appointment on a fee-for-service or on a part-time salary. The Commissioner of Public Health in his reply had stated that the matter had been discussed with the Commonwealth Director of Tuberculosis, Sir Harry Wunderly, and that he had stated that the Commonwealth would not depart from a sessional basis of payment for such appointments. The General Secretary said that the matter had been submitted to the Branches. The Queensland Branch did not agree with the attitude of the Western Australian Branch. The New South Wales Branch expressed the view that where a hospital required the services of an anæsthetist for regular sessions of one or more per week, the payment should be made by salary estimated on the basis of 49 sessions *per annum*, and that where the services of the anæsthetist were required for urgent work, payment for such work should be additional to the annual salary, and should be at the sessional rate. The Victorian Branch had left the matter in the hands of its delegates. The South Australian Branch did not think that any objection could be raised to the employment of an anæsthetist on a sessional basis. The Tasmanian Branch thought that as a sessional payment had been accepted they had to agree, but thought that the fees payable were inadequate. It was pointed out in discussion that when payment was made on a sessional basis, very often it happened that at the last moment, owing to indisposition of the surgeon or some intervening condition suffered by the patient, operation had to be postponed, and the entire session was lost, the anæsthetist being unable to fill up his time at the last moment. After discussion the Federal Council resolved that in its opinion, where a hospital required the service of an anæsthetist for regular sessions of one or more per week, payment should be made by salary estimated on the basis of 49 sessions *per annum*, and that where the services of the anæsthetist were required for urgent work, payment for such work should be additional to the annual salary, which should be at sessional rates.

PUBLICITY COMMITTEE.

The Publicity Committee of the Federal Council was reappointed as follows: Sir Archibald Collins, Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. E. Lee, Dr. L. R. Mallen and Dr. C. H. Dickson.

AUSTRALIAN POST-GRADUATE FEDERATION IN MEDICINE.

The General Secretary said that he had received from the Australian Post-Graduate Federation in Medicine several documents: notices of the general meeting of October 12, 1954, and of the seventh annual general meeting of October 12, 1954, both at Sydney; minutes of the general meeting of October 12, 1954, and of the seventh annual general meeting of October, 1954. He had also received a copy of the recommendation of the Post-Graduate Committee in Medicine in the University of Sydney in regard to the classification of overseas lecturers in categories B1 and B2.

FEDERAL COUNCIL MEDICAL MONOGRAPH FUND.

The General Secretary said that the Federal Council Medical Monograph Fund stood at a total of £2329 9s. 8d. A sum of £2000 had been invested in Commonwealth Bonds. The Federal Council gave authority for the affixing of the Council's seal to the trust deed of the fund.

BRITISH MEDICAL ASSOCIATION.

The General Secretary said that he had received a notice of the Annual Representative Meeting, to be held in London on June 1 to 4, 1955, a copy of which had also been sent to the Branches.

The General Secretary had received from the Parent Body inquiries in regard to several advertisements which had been offered for insertion in the *British Medical Journal*. He had also received from the editor of the *British Medical Journal* a copy of the reprint of the account of the First World Conference on Medical Education. The London office had asked for copies of the Australian *National Health Act*, 1953, and of the *Therapeutic Substances Act*.

A communication had been received from the Medical Association of South Africa, advising of a resolution expressing appreciation of the services rendered to students from South Africa by the Empire Medical Advisory Bureau. An expression of appreciation would be conveyed by the South African Medical Association to the President of the British Medical Association at the British Commonwealth Medical Conference to be held at Toronto. It was pointed out that the South African Medical Association was an association affiliated with the British Medical Association, whereas the Australian Branches were part of the organization of the Association. Although the Australian Branches were in a somewhat different category from that of the South African Medical Association, the Federal Council decided that it should be associated with the expression of appreciation of the work of the Empire Medical Advisory Bureau.

The General Secretary said that he had received from the Empire Medical Advisory Bureau a copy of the summary of regulations for post-graduate diplomas and courses of instruction in post-graduate medicine in Great Britain.

BRITISH COMMONWEALTH MEDICAL CONFERENCE.

At its meeting in August, 1954, the Federal Council appointed Dr. H. R. R. Grieve as its representative to attend the British Commonwealth Medical Conference to be held at Toronto in June, 1955. The General Secretary said that Dr. Grieve had been compelled to cancel his acceptance of the appointment. The Federal Council then appointed Dr. Robert Southby to be delegate of the Council to attend the conference at Toronto.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL.

Dr. W. F. Simmons, the representative of the Federal Council on the National Health and Medical Research Council, had written to the General Secretary, asking whether the Federal Council or the Branches wished to have any items placed on the agenda of the next meeting of the Council. The request had been conveyed to the Branches. The Victorian Branch had asked that the National Health and Medical Research Council should be asked to constitute an inquiry into methods of annotation of dosages of radiation. Dr. Simmons said that the request of the Victorian Branch had been appreciated, and that a report was being prepared on the subject and would be presented at the session of the National Health and Medical Research Council in May, 1955.

The General Secretary referred to the report by Dr. Simmons of the last meeting of the National Health and Medical Research Council, and the Federal Council thanked Dr. Simmons for his report.

The General Secretary said that Dr. Simmons had forwarded the following documents which he had received from Dr. A. J. Metcalfe, the chairman of the National Health and Medical Research Council, the documents having been prepared by the Department of Scientific and Industrial Research of Great Britain: "Some Preliminary Measurements of the Shock-Absorbing Properties of Motor-Cyclists' Crash Helmets", "A Comparison of the Heat Absorption of Different Surface Finishes for Crash Helmets".

COMMONWEALTH DEPARTMENT OF HEALTH.

The General Secretary said that he had received from the Director-General of Health inquiries in regard to the desirability of discontinuance of the use of *Cannabis Indica*. The matter had been referred to the Branches, and all the Branches had agreed that the use of the drug should be discontinued. The General Secretary had forwarded the decision to the Director-General of Health.

A communication had been received from the Director-General of Health, inquiring in regard to the prevailing rates of payment for *locum tenentes*. He had replied that the average payment was 30 guineas per week. The General Secretary said that he had received a letter from the Director-General of Health in regard to restriction of the use of erythromycin. In his letter the Director-General pointed out that erythromycin was effective chiefly against Gram-positive cocci, its spectrum of activity being similar to that of penicillin. It was also active against *Hæmophilus pertussis*. It had been shown that organisms would quickly develop resistance to erythromycin. It was felt that the use of this antibiotic should be limited to the treatment of infections caused by organisms which were resistant to all other antibiotics. This restricted use would prolong the period of maximum value of this antibiotic, and should delay the appearance of resistant strains of organisms. The Antibiotics Committee of the National Health and Medical Research Council had recommended to that council in 1953 and again in 1954 that distribution of erythromycin should be restricted to hospitals. By this means it was hoped that it would be possible in the great majority of instances to establish that the organisms causing the infection to be treated were in fact "resistant to all other antibiotics". The council had accepted this recommendation of the Antibiotics Committee. The Director-General pointed out that there was no legal authority for their controlling the use of erythromycin, which was being freely supplied to retail pharmacists. The members of the Antibiotics Committee were alarmed that widespread use of erythromycin might lead to the appearance of resistant organisms, and it asked the Federal Council to appeal to all its members to restrict wherever possible the use of this valuable antibiotic to infections caused by organisms resistant to all other antibiotics. The General Secretary said that the Western Australian, South Australian and New South Wales Branches had replied and had agreed with the suggestion made by the Director-General.

WORLD MEDICAL ASSOCIATION.

The General Secretary said that he had received from Dr. L. R. Mallen and Dr. H. W. Horn (delegates) and Dr. Mervyn Archdall (alternate delegate) a report of the eighth general assembly of the World Medical Association, held at Rome from September 26 to October 2, 1954. The report had been sent to the Branches. It was resolved that the authors of the report should be thanked for it.

The General Secretary said that he had received from the Secretary-General of the World Medical Association a copy of the minutes of the eighth general assembly.

A report had been received from Dr. L. R. Mallen of the twenty-first and twenty-second council meetings of the World Medical Association, and the minutes of these meetings had also been received from the Secretary-General.

The General Secretary said that he had received several newsletters from the Secretary-General of the World Medical Association, and that these had been sent to the Branches.

The General Secretary said that he had received from the Secretary-General of the World Medical Association a letter requesting that a committee should be constituted by the Federal Council to examine, comment upon and criticize the first proceedings of the Conference on Medical Education, particularly in relation to medical education in Australia, and to report to the Medical Education Committee of the World Medical Association not later than March, 1956. The Federal Council resolved that the Branches in each of the four States having a medical school should be asked to appoint a committee to examine, comment upon and criticize the proceedings of the First World Conference on Medical Education, particularly in relation to medical education in their own State, and to appoint a representative to confer with representatives from the other States with a view to preparing a coordinated report on the matter for the Federal Council to submit to the Medical Education Committee of the World Medical Association.

The General Secretary said that the twelve principles of social security had been reaffirmed by the eighth general assembly of the World Medical Association. These had been sent on to the Branches.

The Secretary-General of the World Medical Association had sent a copy of a statement on the current status of negotiations between the World Medical Association and the International Society Security Association adopted at the eighth general assembly in Rome. The Secretary-General had also sent a copy of a statement adopted by the eighth general assembly in regard to the resolution of the International Social Security Association.

The Secretary-General had sent a copy of the resolution adopted by the eighth general assembly on experiments on human beings. This subject was discussed in a leading article in this journal in the issue of December 18, 1954.

The Secretary-General of the World Medical Association had also sent a statement dealing with a preliminary report on an investigation being carried out by the World Health Organization on international law. It was held that if there was to be any international law, it should be formulated by medically trained persons.

The General Secretary said that he had received from the Secretary-General of the World Medical Association a financial *questionnaire*. The document consisted of five questions. These were discussed by the Federal Council and were answered as follows: Question 1: Will your Association agree that the amount of money raised by each country for the W.M.A. should be the equivalent of one Swiss franc per member of the national association? Answer: Yes. Question 2: What amount can be contributed yearly direct by your Association? Answer: One Swiss franc per member. Question 3: What amount can be contributed through a supporting committee? Answer: Uncertain at this juncture. Question 4: Pending approval of any increase in dues, does your Association feel it can voluntarily increase its payment to W.M.A. by (*a*) a supplementary gift in addition to present dues; (*b*) by a voluntary increase in dues to one Swiss franc per member; (*c*) by contributions from a supporting committee? Answer: By a voluntary increase in dues to one Swiss franc per member. Question 5: Until such time as the income of the Association will permit it to assume the expenses of Council and Committee members attending meetings of the Council (which it is hoped will be within the next two years), will your Association in the case of any Council or Committee members from your Association defray these costs? Answer: No.

The General Secretary said that he had received other *questionnaires*. These included one on professional income tax deductions, another on membership statistics, another on a conference of member association secretaries, another on information. These had either been completed or referred to the Branches for information. The General Secretary reported that he had been reappointed as secretary for Australasia.

The General Secretary pointed out that the Federal Council had to elect a delegate to attend the ninth general assembly at Vienna on September 20 to 26, 1955. The Federal Council appointed Dr. L. R. Mallen as its delegate. It also resolved that the appointment of alternate delegates and observers to the ninth general assembly should be left in the hands of the President and the General Secretary.

At the previous meeting of the Federal Council consideration was given to the suggestion that a member of the practising profession should be sent from member countries of the World Medical Association to attend the World Health Assembly of the World Health Organization. It was resolved that representations should be made to the Minister for Health that consideration should be given to the appointment of a member of the practising profession of Australia as the representative of the Government at meetings of the World Health Organization.

The Federal Council finally resolved that the annual subscription of the Federal Council to the World Medical Association be paid at the rate of one Swiss franc per member of the British Medical Association in Australia.

REPATRIATION DEPARTMENT.

The Treatment of Widows, Widowed Mothers and Orphans of the 1914-1918 and 1939-1945 Wars: Fees Payable to Local Medical Officers.

The Federal Council discussed the failure of the Repatriation Department to reply to communications about the fees payable for the treatment of widows, widowed mothers and orphans of the 1914-1918 and 1939-1945 wars, and also the failure of response in connexion with fees payable to local medical officers for emergency treatment at week-ends and

on holidays. It was pointed out that the fees at present paid in respect of widows and orphans were the only per-capita payment fees at present existing in the Commonwealth. In regard to all these matters repeated representations had been made. The Federal Council resolved to inform the Repatriation Commission that, failing agreement on the items mentioned, the Council would advise members of the British Medical Association to cancel their agreements with the Commission as from June 30, 1955.

Consultation at a Specialist's Rooms.

The question of consultation at a specialist's rooms had been dealt with at the previous meeting. No action was taken as a decision was awaited in the margins case; so there was really nothing to report.

Fees Payable to Visiting Medical Officers.

At its meeting in August, 1954, the Federal Council discussed the fees payable to visiting medical officers of the Repatriation Department. At that meeting great dissatisfaction was expressed at the fees which were offered to visiting medical officers. It had been noted at the previous meeting that the Minister for Repatriation had indicated his willingness to discuss rates of payment of visiting medical officers should the necessity arise. It was resolved then that the Federal Council should seek an interview with the Minister for Repatriation, and arrangements for the holding of such a conference were left in the hands of the President and the General Secretary. It had not been possible to arrange this interview. The Federal Council now had before it two documents; one was from the Victorian Branch. In this document it was pointed out that a meeting of the Association of Visiting Specialist Medical Officers of the Repatriation Department in Victoria had held a meeting in November, 1954, and had resolved that fees should be set at a minimum of £6 6s. for the first hour, increasing by two guineas per hour, and that these fees were not to be inclusive of travelling allowance. It was thought that for emergency work between the hours of 8 p.m. and 8 a.m. on Saturdays, Sundays and public holidays the fees should be at the rate of 50% higher than the usual fees, the maximum fees for emergency work thus being brought to nine guineas for the first hour, this amount to be increased by two guineas per hour after the first hour. It was thought that the scale of fees should be opened for discussion at future dates when necessary. It was finally stated that the Association of Visiting Specialist Medical Officers wished to deal through the Victorian Branch of the British Medical Association direct with the Federal Council, and that notification of all decisions and motions should be submitted to equivalent bodies in other States. The second document before the Federal Council came from The Royal Australasian College of Physicians. In the covering letter to this document it was stated that the question of the conditions of appointment and remuneration of visiting medical officers to the Repatriation Commission had been considered after representations had been made by certain Fellows of the College. A subcommittee had been appointed to obtain information on the matter, and inquiries had been made in all States of the Commonwealth. The subcommittees had prepared a draft memorandum for submission to meetings of the visiting medical officers in each State. A copy of this memorandum was sent with the covering letter. General approval of the principle embodied in the memorandum had been given in Western Australia, South Australia, Tasmania, Victoria and New South Wales, but no information was so far available in regard to the attitude of visiting medical officers in Queensland. The memorandum had been submitted to and had been approved by the Council of the College at its meeting in October, 1954. The Council of the College had adopted a recommendation that it should enter into negotiations with other specialist bodies, particularly the Royal Australasian College of Surgeons and the Federal Council of the British Medical Association in Australia, with a view to presenting a considered opinion on the specialist medical services of the Repatriation Department to the Prime Minister. The Royal Australasian College of Physicians therefore suggested that a conference should be held between representatives of the British Medical Association, the Royal Australasian College of Surgeons and The Royal Australasian College of Physicians at which all aspects of the subject might be considered. The General Secretary reported that these documents had been sent to the Branches. Dr. A. E. Lee pointed out that the fees suggested by the visiting medical officers of Heidelberg Hospital were flat fees. He did not think that they were fair, because they made no distinction between senior and junior visiting medical officers. He did not think that a junior medical officer should receive the same remuneration as a senior. The New South Wales Branch thought that the fees were too high, and that the remuneration should be four guineas for the first hour with an increase of two guineas per hour afterwards. The President said that the important consideration about visiting medical officers and their work was that the visiting staff should have complete control of treatment. After further discussion the Federal Council resolved that it did not approve of the rates of payment of visiting medical officers of repatriation hospitals recommended by the visiting medical officers of the Heidelberg Repatriation Hospital, Victoria. It thought that the fees payable to visiting medical officers of Repatriation Department hospitals should be four guineas for the first hour and two guineas for every subsequent hour or part thereof, such fees not to include travelling allowances. The Federal Council resolved that it would invite representatives of the Royal Australasian College of Surgeons, of The Royal Australasian College of Physicians, and of the salaried members of the staffs of repatriation hospitals to a conference with a view to devising means of improving the efficiency of repatriation hospitals, and that a report of the conference should be forwarded to the Branches for their consideration. It was resolved that Sir Archibald Collins, Dr. A. E. Lee, Dr. A. J. Murray and the General Secretary should be the representatives of the Federal Council at the conference.

Fees Payable to Medical Practitioners Acting on Assessment Appeal Tribunals.

At the August, 1954, meeting of the Federal Council, reference was made to the fees payable to medical officers of assessment appeal tribunals. It was held that the fee of five guineas was inadequate, and it was resolved that a request should be made for an increase of the fee to ten guineas. At the August meeting of the Federal Council it had been resolved that no further action should be taken in the matter. The General Secretary, however, pointed out that the Ophthalmological Society of Australia (British Medical Association) had written to the Federal Council protesting that the present fee of five guineas was inadequate, and asking that appropriate action should be taken. After discussion the Federal Council resolved to leave the matter in the hands of the General Secretary.

Salaried Medical Officers.

A communication was received from Dr. J. B. Best, the secretary of the Repatriation Department Medical Officers' Association, advising of the present position of the appeal for a variation in rates of payment, and asking for financial support of the Federal Council. It was desired to undertake an appeal to the Full Arbitration Court against a decision of the Public Service Arbitrator, who had refused on the application of the Repatriation Medical Officers' Association to vary Determination Number 6 of 1950 in relation to salaries and certain conditions of service. It was pointed out that the Federal Council had helped the repatriation medical officers financially on a previous occasion. Dr. Best sent a table, in which were set out the standard salary range as at December 1, 1954, the new actual salary as from December 23, 1954, and the new actual salary for clerks of the same salary range as medical officers as at January 1, 1954. The medical officers' salary was not as high as that of the clerks. It was pointed out in discussion that the repatriation medical officers were not the only medical officers interested in this appeal to the Arbitration Court, because the decisions would affect the salaries of medical officers in all government departments. Although the repatriation medical officers had subscribed to a fund to enable legal action to be taken, it was thought by members of the Federal Council that they should spread their net a little more widely and appeal for financial support to all salaried medical officers. After further discussion the Federal Council resolved to give financial assistance to the Repatriation Department Medical Officers' Association in its appeal to the Arbitration Court. It was thought that the money should be taken from the Organization Fund of the Federal Council, and it was resolved that the sum of £500 should be offered to the Repatriation Department Medical Officers' Association.

An inquiry was received by the Federal Council from the Victorian Branch, asking whether the Council had at any time stated what should be considered the minimum remuneration for a fully qualified specialist. The view was expressed that before a reply could be given, the result of the appeal by the Repatriation Medical Officers' Association should be awaited. The matter was then left in the hands of the General Secretary.

COMMONWEALTH EMPLOYEES' COMPENSATION ACT.

At a previous meeting of the Federal Council reference had been made to fees for atendance on injured workers under the provisions of the *Commonwealth Employees' Compensation Act*. The General Secretary said that a reply was still awaited from the Commissioner for Employees' Compensation.

DEPARTMENT OF THE ARMY.

Reference was made to the fees payable to area medical officers of the Commonwealth Military Forces, and also to fees payable to civil medical practitioners carrying out work for the Department of the Army. It was decided to leave discussion of this matter until the result of the margins case was made known.

FEES FOR MEDICAL INSPECTION OF SEAMEN.

At the August, 1954, meeting of the Council, the Federal Council resolved that a request should be made to the Minister for Shipping that the fees payable to a medical inspector of seamen who was not a member of the Commonwealth Public Service for the medical examination of a seaman or apprentice during official hours be increased to £1 1s. when the examination was conducted at the surgery, and to £1 5s. when the examination was conducted at the home. The General Secretary said that a reply had been received from the Minister for Shipping and Transport, advising that action was already being taken at the suggestion of the Department of Health to amend the regulations to provide for payment of additional fees, but that the amounts, which would not be less than those prescribed for other similar services, had not so far been decided. It was decided to allow the matter to stand over.

LONDON HOUSE.

The Honorary Treasurer, Dr. W. F. Simmons, reported that the total subscribed throughout the Commonwealth to the fund for London House was £742 10s. It was resolved that the fund should be closed on March 31, 1955, and that the amount standing to the credit of the fund should be forwarded to the Comptroller of London House, Brigadier E. C. Pepper.

BRITISH PHARMACOPŒIA COMMISSION.

The General Secretary reported that he had received from Dr. Byron Stanton his recommendations regarding the revision of the British Pharmacopœia. Dr. Stanton had been compelled to delay his reply on account of ill health. The Federal Council resolved to thank Dr. Stanton for his valuable assistance.

AUSTRALIAN ROAD SAFETY COUNCIL.

At the August, 1954, meeting of the Federal Council it was resolved that Dr. F. S. Hansman should be appointed the representative of the Federal Council to attend the annual congress of the Australian Road Safety Council, to be held in Hobart on November 16 to 19, 1954. The General Secretary reported that he had received a letter from Dr. Hansman expressing his appreciation of the action of the Federal Council in appointing him as its representative, and enclosing a copy of the address which he proposed to deliver at a public meeting to be held during the course of the congress. The General Secretary said that he had also received a most appreciative letter from the Australian Road Safety Council, in which Dr. Hansman's address was described as very valuable.

SUPERANNUATION FOR SELF-EMPLOYED PERSONS.

A letter was received from the Victorian Branch, stating that certain professional bodies, which were listed, had agreed to support an approach to the Government towards the obtaining of tax relief to enable self-employed persons to provide for their retirement. The Victorian Branch Council had adopted certain resolutions, a copy of which were enclosed with the Branch letter. The Federal Council after discussion adopted a resolution stating that it approved of the proposed establishment of a scheme of superannuation for self-employed persons in Australia. It appointed Dr. H. C. Colville, Dr. C. Byrne and Dr. R. Southby a committee to confer with other professional organizations, with a view to an approach being made to the Federal Treasurer in the matter of seeking the establishment of a scheme of superannuation for self-employed persons in Australia.

PUBLICATION OF THE NAMES OF DRUGS CAUSING ACCIDENTAL OR SUICIDAL DEATHS.

A letter was received from the Queensland Branch, recommending that steps should be taken to prevent the publication of the well-known names of drugs causing accidental or suicidal deaths, and that perhaps the full chemical name might be substituted. In its letter the Queensland Branch stated that it had been held on good authority that an increase in cases of attempted suicide occurred regularly after the publication of each successful suicide. The General Secretary said that the matter had been referred to the Branches. The New South Wales Branch had expressed the opinion that the names of drugs causing accidental or suicidal death should not appear in the Press. The Victorian Branch supported the Queensland Branch proposal. The South Australian Branch thought that no useful purpose would be achieved by proceeding further in the matter. The Western Australian Branch agreed with the proposals outlined by the Queensland Branch. The Tasmanian Branch with its reply sent the copy of a letter stating the opinion of Dr. C. Duncan, the Government Pathologist, whose advice had been obtained on the matter. In his letter Dr. Duncan stated that, first of all in regard to murder cases, it was obvious that the name of a particular preparation would have to be mentioned in the evidence, probably several times. As these cases had to be held in open court, the publication in a newspaper of the name of a preparation was entirely a matter for the editor of the newspaper concerned, though occasionally a judge would ask a reporter not to publish something. As far as Dr. Duncan knew, even a judge could not prevent the publication of evidence given in court before a jury in the usual way, though he could do so if the evidence was given in the absence of a jury. In regard to coroners' inquests on suicide, here again the coroner could ask but not demand that the Press should not publish certain evidence. Dr. Duncan concluded by stating that from a study of nearly 400 cases of suicide in Tasmania, he doubted whether publishing the details of a suicide including the method used was of the slightest significance. It was resolved that the General Secretary should write to the Newspaper Proprietors' Association on the subject.

DEPARTMENT OF SOCIAL SERVICES.

A letter was received from the New South Wales Branch, asking that consideration should be given to the making of an approach to the Department of Social Services with a view to an increase in the fee for examination of pensioners to £1 11s. 6d. After a discussion in which some divergent views were expressed, the Federal Council resolved to make the approach requested by the New South Wales Branch.

Reference was made to the fees payable for examination by specialists, radiologists *et cetera* for invalid pension purposes. The Federal Council had before it a communication from the Director-General of the Department of Social Services setting out the fees which were payable. In the course of his reply the Director-General of Social Services stated that all directors of social services had been informed that, in respect of future examinations and reports for invalid pension purposes, fees could be paid on the same basis as by the Repatriation Department—namely, (*a*) for examination and report a fee up to £2 10s. for a first visit and £1 1s. for each subsequent visit relating to the same examination. This sum might be paid to all doctors with recognized specialist qualifications who made examinations at their rooms of patients referred to them by the Department. When it was considered necessary to refer a patient to a specialist recognized as a leader in the profession, a fee up to three guineas might be paid for the first visit, *plus* one guinea for each later visit relating to the same examination. Where a specialist was unable to form an opinion from clinical examination and some additional investigatory procedure or test was regarded as essential, payment therefore might be made on a fee-for-service basis. For examination, X ray and report by a radiologist, a fee might be paid in accordance with a scale which was attached to the letter. The communication was noted.

A letter was received from the Victorian Branch, asking for consideration of the *Social Services Consolidation Act*, Section 141, dealing with information about pensioners. The Victorian Branch made this request in view of the fact that a member of the Branch had been asked by the Registrar of Social Services for disclosure of information. The matter was left in the hands of the General Secretary.

DEPARTMENT OF LABOUR AND NATIONAL SERVICE.

A letter was received from the secretary of the Department of Labour and National Service, inquiring whether a fee of one guinea would be satisfactory to the medical pro-

fession for the provision of clinical notes regarding the classification of a registrant for national service purposes. The matter had been referred to the Branches. The Federal Council resolved that a fee of one guinea was satisfactory.

MEDICAL EXAMINATION FOR PILOTS' LICENCES FOR AIRCRAFT.

A letter was received from the South Australian Branch, asking that the fee for reexamination of pilots for licences in regard to aircraft should be increased from £1 11s. 6d. to £2 2s. In March, 1949, it had been resolved that the fee for medical examination for pilots' licences for aircraft should be two guineas for the initial examination and one and a half guineas for the reexamination. The South Australian Branch did not agree that the fee should be reduced for this service, even though many of the persons to be examined were young men and were learning to fly on their own initiative. The Federal Council adopted the recommendation of the South Australian Branch.

DATE AND PLACE OF THE NEXT MEETING.

It was resolved that the next meeting of the Federal Council should be held at Sydney on Wednesday, August 17, 1955, commencing at 2.15 o'clock p.m.

VOTES OF THANKS.

It was resolved that the thanks of the Federal Council should be extended to the Council of the Victorian Branch for its hospitality and for the accommodation provided for the meeting. It was resolved that Dr. H. C. Colville, Dr. C. Byrne and Dr. R. Southby should be thanked for their hospitality, and that the thanks of the meeting should be extended to Dr. J. G. Hunter and Miss Cameron for their services during the meeting.

It was resolved on the motion of Dr. H. C. Colville that the thanks of the meeting should be extended to the President, Sir Archibald Collins, for presiding.

THE BRITISH MEDICAL ASSOCIATION ANNUAL GENERAL MEETING, 1935, PRIZE.

THE British Medical Association Annual General Meeting, 1935, Prize is open to all members of the Association in Australia and its Mandated Territories and in New Zealand, and to any graduate of an Australian university who is a member of the Association.

The prize is to be awarded for that contribution towards the study of problems in the medical and allied sciences adjudged to be of greatest merit. If no contribution is considered to be of sufficent merit, the prize may not be awarded.

The prize shall consist of a medal suitably inscribed, together with the balance of the income from the capital fund available for distribution at the time.

The period during which any contribution for consideration may be made shall be the three years ending on December 31 immediately preceding a meeting of the Australasian Medical Congress (British Medical Association).

This is a triennial prize, and it is intended that it may be awarded for the second time at the meeting of Congress to be held in Sydney in August, 1955.

To minimize the risk that a contribution of high value may be overlooked, it will be appreciated if the contributor of any such work complying with the above conditions be nominated to the Prize Committee. It is requested that such nominations be forwarded not later than April 30, 1955, to Dr. J. P. Major, Chairman of the Prize Committee, British Medical Association (Victorian Branch), 426 Albert Street, East Melbourne, C.2.

Research.

THE ROYAL SOCIETY.

Tropical Research Fellowship (Medical Sciences).

APPLICATIONS are invited by the Council of the Royal Society for a research fellowship with special reference to ill health in the tropics. The fellowship is tenable in any university, hospital or medical school or other institution approved by the Royal Society in the British Commonwealth. The successful applicant, who need not necessarily hold a medical qualification, will be expected to spend some part of the period of tenure in the tropics.

The appointment will be for two years in the first instance, from October 1, 1955, and may be renewed annually up to a total of five years. It will be subject to the conditions governing Royal Society research appointments. The stipend will be £1250 *per annum*.

Applications, which should be made on forms to be obtained from the Assistant Secretary, The Royal Society, Burlington House, London, W.1, should be received as early as possible, in any case not later than May 31, 1955.

Post-Graduate Work.

THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

Lecture at Balmoral Naval Hospital.

THE Post-Graduate Committee in Medicine in the University of Sydney announces that Dr. P. J. Kenny will give a lecture on "Surgical Approaches to Limb Structures" on Tuesday, April 5, 1955, at 2 p.m. at the Balmoral Naval Hospital. Clinical cases will be shown after the lecture. All medical practitioners are invited to attend.

Week-End Course at Wagga Wagga.

The Post-Graduate Committee in Medicine in the University of Sydney announces that a week-end course will be held at the Wagga Wagga Base Hospital, in conjunction with the Southern Districts Medical Association, on Saturday and Sunday, April 30 and May 1, 1955. The programme is as follows:

Saturday, April 30: 2.30 p.m., "Uterine Dysfunction", Dr. S. Devenish Meares; 4 p.m., "Psychosomatic Medicine", Dr. David M. Ross.

Sunday, May 1: 10 a.m., "The Management of Compound Fractures", Dr. W. D. Sturrock; 11.30 a.m., "Trends in New Drugs in Obstetrics", Dr. S. Devenish Meares; 2 p.m., "Psychosomatic Disorders in Children", Dr. David M. Ross; 3.30 p.m., "Modern Approach to Traumatic Surgery", Dr. W. D. Sturrock.

The fee for attendance is £3 3s. Those wishing to attend are requested to notify Dr. John L. Tunley, Honorary Secretary, Southern Districts Medical Association, 53 Gurwood Street, Wagga Wagga, New South Wales, as soon as possible.

Week-End Course at Armidale.

The Post-Graduate Committee in Medicine in the University of Sydney, in conjunction with the Northern District Medical Association, will hold a week-end course at Armidale on Saturday and Sunday, April 30 and May 1, 1955, at the New England University College. The programme is as follows:

Saturday, April 30: 2.30 p.m., "Could the Chapter on Eclampsia Disappear?", Professor Bruce T. Mayes; 4 p.m., "Ulcerative Colitis", Dr. T. M. Greenaway and Dr. Kenneth W. Starr.

Sunday, May 1: 9.30 a.m., "The Problem of the Breech", Professor Bruce T. Mayes; 11.15 a.m., "Functional Disorders in General Practice", Dr. T. M. Greenaway; 2 p.m., "Fractures of the Face and Jaw", Dr. Kenneth W. Starr.

The fee for atendance at the course will be £3 3s. Those wishing to attend are requested to notify Dr. H. G. Royle, Honorary Secretary, Northern District Medical Association, 107 Faulkner Street, Armidale, New South Wales. Telephones: Armidale 60 and 531.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Numbers 5 and 7, of January 27 and February 10, 1955.

CITIZEN NAVAL FORCES OF THE COMMONWEALTH.

Royal Australian Naval Reserve.

To be Surgeon Commander.—Surgeon Lieutenant-Commander Allan Gordon Campbell, D.S.O.

AUSTRALIAN MILITARY FORCES.

Regular Army Special Reserve.

Royal Australian Army Medical Corps.

VX700357 Captain W. B. Fleming relinquishes the temporary rank of Major and is transferred to the Reserve of Officers (Royal Australian Army Medical Corps (Medical)) (3rd Military District), 11th December, 1954.

To be Captain and Temporary Major, 2nd December, 1954.—VX700361 Neil Johnson.

Citizen Military Forces.

Northern Command: First Military District.

Royal Australian Army Medical Corps (Medical).—1/25512 Captain P. W. Leslie is transferred to the Reserve of Officers (Royal Australian Army Medical Corps (Medical)) (1st Military District), 18th November, 1954.

Eastern Command: Second Military District.

Royal Australian Army Medical Corps (Medical).—2/70937 Major A. L. Hellestrand is appointed to command 8th Field Ambulance, and to be Temporary Lieutenant-Colonel, 15th May, 1954 (in lieu of the notification respecting this officer which appeared in Executive Minute No. 125 of 1954, promulgated in *Commonwealth Gazette*, No. 43, of 1954). The notification respecting 2/70937 Captain A. L. Hellestrand, which appeared in Executive Minute No. 150 of 1953, promulgated in *Commonwealth Gazette*, No. 55, of 1953, is withdrawn. To be Major, 16th February, 1953: 2/70937 Captain A. L. Hellestrand. The provisional appointments of the following officers are terminated: Captains 2/146600 R. G. R. Sim, 24th September, 1954, and 2/206956 G. L. McDonald, 5th November, 1954. To be Captains (provisionally): 2/146600 Robert George Robertson Sim, 25th September, 1954, and 2/206956 Geoffrey Lance McDonald, 6th November, 1954.

Western Command: Fifth Military District.

Royal Australian Army Medical Corps (Medical).—5/26526 Captain (provisionally) P. A. Limbers relinquishes the provisional rank of Captain and is transferred to the Reserve of Officers (Royal Australian Army Medical Corps (Medical)) (5th Military District) in the honorary rank of Captain, 29th October, 1954. The provisional appointment of 5/26518 Captain W. N. Gilmour is terminated, 23rd August, 1954. To be Captain (provisionally), 24th August, 1954: 5/26518 William Norman Gilmour.

ROYAL AUSTRALIAN AIR FORCE.

Permanent Air Force: Medical Branch.

Flight Lieutenant M. N. McLaughlin (024303) is granted the acting rank of Squadron Leader, 1st December, 1954.

Active Citizen Air Force: Medical Branch.

No. 21 (City of Melbourne) Squadron.—Flying Officer (Temporary Flight Lieutenant) J. E. H. Milne (0311677) is transferred from the Reserve, 19th November, 1954, with the rank of Flight Lieutenant.

Australian Medical Board Proceedings.

QUEENSLAND.

THE following have been registered, pursuant to the provisions of *The Medical Acts, 1939 to 1948*, as duly qualified medical practitioners: Manning, Rene Lionel, M.B., B.S., 1952 (Univ. Sydney); Tyrer, John Howard, M.B., B.S., 1942 (Univ. Sydney), M.D., 1953 (Univ. Sydney), M.R.A.C.P., 1949, M.R.C.P. (London), 1953; O'Reilly, Cyril Francis, M.B., B.Ch., 1936 (Queen's Univ., Belfast), D.P.H., 1940 (Univ. Dublin); Robinson, Charlotte Sophia, M.B., Ch.B., 1943 (Univ. Glasgow).

The following additional qualifications have been registered: Pike, Kenneth Henry, D.T.M. and H. (Sydney), 1953; Horn, Marie Laura, M.R.C.P. (Edinburgh), 1954.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED MARCH 5, 1955.[1]

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	5(4)	5(3)	1	1(1)	5(1)	..	..	..	17
Amœbiasis	..	..	..	..	..	..	..	..	..
Ancylostomiasis	1	..	..	..	..	..	1	..	2
Anthrax	..	..	..	..	..	..	..	..	..
Bilharziasis	..	..	..	..	..	..	..	..	..
Brucellosis	..	..	..	..	..	..	..	..	..
Cholera	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus)	..	..	..	..	..	..	..	..	..
Dengue	..	..	..	..	..	..	..	..	..
Diarrhœa (Infantile)	7(3)	38(27)	1(1)	..	1	..	..	..	47
Diphtheria	2	1(1)	..	..	2(2)	..	..	..	5
Dysentery (Bacillary)	..	5(4)	4(3)	..	2(2)	2(1)	..	..	13
Encephalitis	..	3(2)	..	..	..	..	..	..	3
Filariasis	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice	..	..	..	..	..	..	..	..	..
Hydatid	..	..	..	..	..	..	..	..	..
Infective Hepatitis	63(31)	47(27)	..	9(5)	3	1	..	1	124
Lead Poisoning	..	..	..	1(1)	..	..	..	..	1
Leprosy	..	..	..	..	..	..	..	..	..
Leptospirosis	..	..	1	..	..	..	1	..	2
Malaria	..	1	..	..	..	..	..	..	1
Meningococcal Infection	..	2(1)	..	1(1)	..	..	..	..	3
Ophthalmia	..	..	..	..	..	..	..	..	..
Ornithosis	..	..	..	..	..	..	..	..	..
Paratyphoid	1(1)	..	..	..	..	..	..	..	1
Plague	..	..	..	..	..	..	..	..	..
Poliomyelitis	5(2)	12(6)	10(3)	3(2)	..	..	..	..	30
Puerperal Fever	..	..	1	..	..	..	..	..	1
Rubella	..	9(7)	..	..	16(14)	..	..	..	25
Salmonella Infection	..	..	..	..	7(4)	..	..	..	7
Scarlet Fever	6(4)	25(17)	7(5)	3(2)	..	..	..	..	41
Smallpox	..	..	..	..	..	..	..	..	..
Tetanus	..	..	..	1	..	..	..	..	1
Trachoma	..	..	..	..	14	..	..	..	14
Trichinosis	..	..	..	..	..	..	..	..	..
Tuberculosis	17(15)	18(11)	18(6)	4(3)	14(10)	2(1)	1	..	74
Typhoid Fever	3	1(1)	..	..	1(1)	1	..	..	6
Typhus (Flea-, Mite- and Tick-borne)	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne)	..	..	..	..	..	..	..	..	..
Yellow Fever	..	..	..	..	..	..	..	..	..

[1] Figures in parentheses are those for the metropolitan area.

The undermentioned has been registered, pursuant to the provisions of *The Medical Acts, 1939 to 1948*, as a specialist in the following specialties: Horn, Marie Laura, pædiatrics and medicine.

The following have been registered, pursuant to the provisions of *The Medical Acts, 1939 to 1948*, as duly qualified medical practitioners, the qualification being in each case M.B., B.S., 1954 (Univ. Queensland): Adair, Cecil James; Allan, Beverley Chaloner; Bickerton, Sidney Douglas; Blake, William; Boyd, Lorna; Breen, John Joseph; Brown, Bryan Watson; Brown, Thomas Maxwell; Burgess, George Jack; Carroll, John Patrick; Cary, Ian Egerton; Cochran, Joan; Cohney, Benjamin Coplan; Cole, Brian Sidney; Cooper, Robin Gavine; Cope, John Brian; Cross, Ronald Bruce; Emmett, John Albert Jephson; Fielding, George Durward; Fry, Frank Kennedy; George, Frederick Allan; Havig, Gwenyth Jean; Hirschfeld, Keith Elliott; Hockin, Ralph Lionel; Hogg, David Frederick; Jackson, Leonard William Lamont; Jobbins, Leslie Keith; Kehoe, Myles Michael; Kelly, Anthony Alder; Kennedy, Kevin Patrick; Knapp, Bernard Joseph; Kynaston, Bruce; Laister, William Joseph; Livingstone, Peter Gordon; McCafferty, Powell Joseph; McGrath, Terence Michael; McLachlan, Kevin Leslie; MacLennan, Robert; Marrinan, Clement Grattan; Masel, John Philip; Masel, Leslie Francis; Meehan, Brian Clement; Mezger, Mark Louis; Millroy, Peter John; Neilsen, Reginald Sydney; Nommensen, Clement Frederick; O'Donnell, John Edmond; Perrin, Leslie Albert; Pickup, Marceline Dorothy Victoria; Pozzi, John Baptist; Pozzi, Phillip Anthony Michael; Reynolds-Lewis, Margaret Mary; Roberts, Gryffydd King; Scanlan, Gerald John; Scanlan, John Francis; Smith, Harry; Somerset, Raglan Fitzroy; Sullivan, Francis Patrick; Thelander, Ian Drake; Thomas, William Laman; Thorpe, Robert Joseph; Tindale, Dorothy Lois; Wassell, James Charles; Waugh, Ronald Ian; Whittaker, Vivian Kenneth Leslie; Lines, Sydney James; Livingstone, John Neville Asquith; Lynch, John Brendan.

MEDICAL PRACTITIONERS' FLOOD RELIEF FUND.

THE Council of the New South Wales Branch of the British Medical Association has opened a fund to assist all medical practitioners who have suffered loss as a result of the recent floods. The loss in many cases has been heavy, and it is hoped that the response of fellow members of the medical profession will be generous. All donations should be sent to the Medical Secretary, New South Wales Branch of the British Medical Association, 135 Macquarie Street, Sydney. They will be acknowledged in the columns of this journal.

Nominations and Elections.

THE undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

House, Harry, M.B., B.S., 1954 (Univ. Sydney), Commonwealth Cottages, Unanderra.

The undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

Gudkovs, Ariss, qualified 1954 (Univ. Adelaide), 354 Anzac Highway, Plympton, South Australia.

Leske, David, qualified 1954 (Univ. Adelaide), 74 Semaphore Road, Semaphore, South Australia.

Mortimer, Isabel Inkster, qualified 1954 (Univ. Adelaide), 77 Payneham Road, St. Peters, South Australia.

Parham, Anthony Robert, M.B., B.S., 1954 (Univ. Adelaide) (qualified 1953), 437 North East Road, Hillcrest, South Australia.

Mussared, Elaine Frances Keele, M.B., B.S., 1953 (Univ. Adelaide) (qualified 1952), 75 Kensington Road, Norwood, South Australia.

Peake, Noel Horace, M.B., B.S., 1954 (Univ. Adelaide), 522 Magill Road, Magill, South Australia.

Webster, Victor Henry, M.B., B.S., 1930 (Univ. Melbourne), Peterborough, South Australia.

Westerman, Roderick Alan, M.B., B.S., 1954 (Univ. Adelaide) (qualified 1953), Alice Springs Hospital, Alice Springs, South Australia.

The undermentioned has been elected as a member of the South Australian Branch of the British Medical Association: Hronsky, Eugenia, qualified 1954 (Univ. Adelaide).

Deaths.

THE following deaths have been announced:

ELKINGTON.—John Simeon Colbrook Elkington, on March 8, 1955, at Mooloolaba, Queensland.

PRITCHARD.—Surgeon Rear-Admiral Denis Adrian Pritchard, on March 11, 1955, at Melbourne.

HUTH.—Emil Huth, on March 15, 1955, at Sydney.

Diary for the Month.

MARCH 29.—New South Wales Branch, B.M.A.: Council Quarterly.
MARCH 31.—New South Wales Branch, B.M.A.: Annual Meeting.
MARCH 31.—South Australian Branch, B.M.A.: Scientific Meeting.
APRIL 1.—Queensland Branch, B.M.A.: General Meeting.
APRIL 5.—New South Wales Branch, B.M.A.: Council (Election of Officers).

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B17): Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All contract practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Norseman Hospital; all contract practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journals unless such notification is received within one month.

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